



April 2016

# DEFENSE HEALTH CARE

DOD Is Meeting Most Mental Health Care Access Standards, but It Needs a Standard for Follow-up Appointments

## Why GAO Did This Study

DOD reports that between 2005 and 2013, the number of individuals who received mental health care through DOD's MHS grew by 32 percent. MHS mental health care is provided free to active duty servicemembers. Reservists and DOD civilians are eligible for MHS care under certain circumstances.

The National Defense Authorization Act for Fiscal Year 2015 contains a provision for GAO to assess the availability and accessibility of mental health care in DOD's MHS for military servicemembers. This report examines, among other things, (1) the mental health care DOD makes available to servicemembers domestically and overseas and (2) the accessibility of mental health care provided to servicemembers domestically and overseas. GAO analyzed recent, available data on MHS mental health utilization, staffing, and appointment access and compared access data to relevant DOD standards. GAO reviewed mental health data from several DOD surveys as well as documents related to MHS mental health care. GAO also interviewed DOD and service officials and representatives from servicemember and provider associations.

## What GAO Recommends

GAO recommends that DOD establish an access standard for mental health follow-up appointments and regularly monitor data on these appointments. DOD concurred with GAO's recommendation.

View [GAO-16-416](#). For more information, contact Randall B. Williamson at (202) 512-7114 or [williamsonr@gao.gov](mailto:williamsonr@gao.gov)

April 2016

## DEFENSE HEALTH CARE

# DOD Is Meeting Most Mental Health Care Access Standards, but It Needs a Standard for Follow-up Appointments

## What GAO Found

The Department of Defense's (DOD) Military Health System (MHS) makes a variety of inpatient and outpatient mental health care available to active duty servicemembers and activated National Guard and Reserve servicemembers (reservists) domestically and overseas through its TRICARE health care system. The type of care includes psychological testing and assessment, psychotherapy, medication management, and inpatient psychiatric care. This care is typically available through military treatment facilities and clinics (direct care), and it is supplemented by care provided through networks of civilian providers (purchased care). In fiscal year 2014, DOD provided 76 percent of 2.9 million outpatient mental health encounters through direct care and 69 percent of 0.2 million inpatient mental health bed days through purchased care. To deliver mental health care, the military services use a range of strategies including telehealth, embedding mental health providers within units, and integrating mental health providers in primary care. While DOD has increased the number of available mental health providers in both direct and purchased care in recent years, DOD data indicate that the military services still face shortages for certain providers, such as psychiatrists. Unlike the care available for active duty servicemembers and activated reservists, MHS mental health care for inactive reservists is generally limited to referrals to non-DOD community resources or, if eligible, the reservists can purchase coverage for health care, including mental health care, through TRICARE Reserve Select, a premium-based health plan for reservists.

DOD data on domestic and overseas direct care from April 2014 through August 2015 show that MHS-wide DOD's access to care standards were generally met for three of four mental health appointment types. However, in the case of routine appointments—initial appointments for a new or exacerbated condition—data show that other than the Air Force, MHS routine mental health appointments generally did not meet the 7-day access standard. DOD and service officials attributed this to several factors, including some appointments being incorrectly coded, thus negatively impacting the routine appointment access results. They told GAO that DOD was taking steps to address the coding problem and improve oversight of mental health access. Additionally, the data show that about 59 percent of mental health appointments are follow-up appointments, which generally do not have an official DOD access standard. Federal internal control standards call for agencies to have sufficient information to monitor agency performance. By not establishing and monitoring a follow-up appointment standard, DOD cannot hold the military services accountable for the majority of mental health care provided in the direct care system. For purchased care, limited access data are available, and DOD instead relies on beneficiary surveys and complaints to monitor access—consistent with methods used by civilian health plans. DOD surveys have identified access problems for some servicemembers. For example, a DOD beneficiary survey estimated that about one-third of active duty servicemembers experienced problems accessing mental health care from 2011 through 2014. Additionally, provider surveys from 2012 and 2013 found that only an estimated 37 percent of civilian mental health providers were accepting any new TRICARE patients. DOD's ongoing efforts to improve oversight of mental health access, including implementing a strategic plan, may help address some of these problems, but it is too early to tell.

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## Abbreviations

DHA	Defense Health Agency
DOD	Department of Defense
DPH	Director of Psychological Health
EBH	Embedded Behavioral Health
HHS	Department of Health and Human Services
J-MHAT	Joint Mental Health Advisory Team
MHS	Military Health System
MHAT	Mental Health Advisory Team
MTF	military treatment facility
NCR	National Capital Region
NDAA	National Defense Authorization Act
TRS	TRICARE Reserve Select

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April 28, 2016

The Honorable John McCain  
Chairman  
The Honorable Jack Reed  
Ranking Member  
Committee on Armed Services  
United States Senate

The Honorable Mac Thornberry  
Chairman  
The Honorable Adam Smith  
Ranking Member  
Committee on Armed Services  
House of Representatives

As part of its mission, the Department of Defense's (DOD) Military Health System (MHS) provides a full range of medical care and services, including mental health care, to eligible individuals in the United States, overseas, and in deployed settings, such as Iraq and Afghanistan.<sup>1</sup> DOD reports that between 2005 and 2013, the number of individuals who received mental health care through DOD's MHS grew by 32 percent.<sup>2</sup> This growth has been attributed to multiple factors, including more referrals to care from mental health screenings and increasing numbers of servicemembers who experienced life-threatening situations while deployed in combat since September 11, 2001 and their resulting need for mental health treatment. Since 2001, DOD has also expanded the use of its civilian workforce to perform combat support functions traditionally performed by military personnel, thereby increasing these civilians' risk for developing post-traumatic stress disorder and other mental health conditions. DOD has experienced challenges in providing mental health

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<sup>1</sup>Generally, eligible individuals include active duty servicemembers and their dependents, medically eligible National Guard and Reserve servicemembers and their dependents, and retirees and their dependents and survivors.

<sup>2</sup>Department of Defense, *Mental Health Counselors for Service Members, Veterans, and Their Families*, DOD/VA Report to the Congress in Response to S. Rep. No. 113-44, at 133, Accompanying S. 1197, the National Defense Authorization Act for Fiscal Year 2014 (Washington, D.C.: Apr. 17, 2015).

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care to meet the needs of its servicemembers, and these challenges have been exacerbated by issues such as nationwide shortages of mental health providers and the pressure to control DOD healthcare costs. In the MHS, care is provided through TRICARE, DOD's regionally structured health care system. Under TRICARE, active duty servicemembers typically receive most of their care in what is known as the direct care component—that is, in military hospitals and clinics referred to as military treatment facilities (MTF). The care provided in MTFs is supplemented by services offered through TRICARE's purchased care networks of civilian providers.

The National Defense Authorization Act (NDAA) for Fiscal Year 2015 contains a provision for us to assess the availability and accessibility of mental health care for servicemembers and deployed DOD civilian employees.<sup>3</sup> This report examines

1. the mental health care DOD makes available to military servicemembers domestically and overseas,
2. the accessibility of the mental health care provided through DOD's MHS to military servicemembers domestically and overseas, and
3. the availability and accessibility of mental health care for military servicemembers and DOD civilians in deployed settings.

In this report, we are focusing on services available to active duty servicemembers, National Guard and Reserve servicemembers, and deployed DOD civilians. Unless otherwise specified, our use of the term "servicemembers" throughout this report is generally meant to include active duty servicemembers and National Guard and Reserve servicemembers. We consider overseas to be those areas in which the MHS provides health care services in Eurasia-Africa, Latin America and Canada, and the Pacific, and we consider deployed settings to be areas to which servicemembers are deployed in support of contingency operations, such as Iraq or Afghanistan. Additionally, in this report, we use the term "mental health provider" to describe a licensed or certified

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<sup>3</sup>The NDAA for Fiscal Year 2015 also required us to carry out a review of DOD policies, procedures, and programs to reduce the stigma associated with mental health treatment for military servicemembers and deployed civilian DOD employees. See GAO, *Human Capital: Additional Actions Needed to Enhance DOD's Efforts to Address Mental Health Care Stigma*, [GAO-16-404](#) (Washington, D.C.: Apr. 18, 2016).



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clinical provider—those that have met the minimum requirements needed to obtain and maintain a license or certification—including psychiatrists, psychologists, mental health nurse practitioners, licensed social workers, and other licensed providers.<sup>4</sup> We did not review other types of mental health personnel, such as administrative staff and technicians. Therefore, in this report, we consider mental health care to be care delivered by licensed or certified clinical providers, and do not include other services such as non-medical counseling provided by individuals such as chaplains.

To examine what mental health care DOD makes available to military servicemembers domestically and overseas, we reviewed relevant DOD and service documentation on mental health care provided in the MHS's direct and purchased care systems. We also reviewed data on utilization of mental health treatment services in both the direct and purchased care systems by active duty servicemembers, including activated reservists, from fiscal years 2009 to 2014.<sup>5</sup> To determine the reliability of the utilization data, we reviewed relevant documentation, discussed this information with the contractor officials that prepared the data, and reviewed the data for reasonableness, outliers, and consistency; as a result, we determined that the data were sufficiently reliable for the objectives of our review.

To examine the availability of mental health providers in the direct care system, we analyzed quarterly mental health staffing reports for fiscal years 2009 through 2015 submitted to DOD from each military service and the National Capital Region (NCR) Medical Directorate.<sup>6</sup> We

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<sup>4</sup>Unlike mental health nurse practitioners, mental health registered nurses are not considered by DOD to be providers because they are not independent practitioners who can independently see patients. Based on this information, which we received from DOD in April 2016, we excluded mental health registered nurses from our analysis where it was possible to do so, with exceptions as noted in this report.

<sup>5</sup>For the purposes of this report, the term “reservist” includes all members of the following six reserve components: the Army National Guard, Army Reserve, Navy Reserve, Marine Corps Reserve, Air National Guard, and Air Force Reserve. We generally considered activated reservists to be those called or ordered to service for more than 30 days. Throughout this report when we present data for, or describe services available to, active duty servicemembers, activated reservists are generally included unless otherwise noted.

<sup>6</sup>The NCR Medical Directorate manages DOD medical facilities within the national capital region, including Walter Reed National Military Medical Center, Fort Belvoir Community Hospital, and their supporting clinics.

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analyzed these reports separately and together to examine staffing level changes from fiscal years 2009 to 2015 and identify any staffing shortages of DOD mental health providers in the direct care system in fiscal year 2015, the most recent fiscal year with complete data available for analysis. To examine mental health provider staffing levels and shortages in the purchased care system, we analyzed provider network adequacy reports from the month of December of each year for 2010 through 2014, and the report for the month of July for 2015, which was the most recent month with complete data available for analysis. To ensure the reliability of the data in the mental health staffing reports and the provider network adequacy reports, we interviewed officials from the Office of the Assistant Secretary of Defense for Health Affairs responsible for collecting and analyzing the quarterly staffing reports, and TRICARE Regional Office officials responsible for collecting and analyzing the monthly network adequacy reports. In addition, we reviewed documentation related to the production of these reports, performed data checks on the network adequacy reports and examined the data for missing values. On the basis of these steps as well as our prior review of the quarterly staffing reports, we found the data to be sufficiently reliable for the purposes of this report.

To further examine the availability of MHS mental health care, we also interviewed officials from the DOD and the military services, specifically the Army, Army Reserve, Navy, Navy Reserve, Air Force, Air Force Reserve, Marine Corps, Marine Corps Reserve, National Guard Bureau, NCR Medical Directorate, Defense Health Agency (DHA), and TRICARE Regional Offices, to learn about the mental health care available to servicemembers and reservists. Because DOD civilians are generally not entitled to MHS health care except when deployed or if they have a health condition determined to be related to their deployment, we did not include DOD civilians in our review of what mental health care DOD makes available domestically and overseas.

To examine the accessibility of mental health care provided through DOD's MHS to military servicemembers domestically and overseas, we reviewed direct care mental health appointment access data from monthly Access to Care Mental Health Summary reports produced by DHA's

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TRICARE Operations Center.<sup>7</sup> We examined mental health appointment access data from April 2014 through August 2015, the most recent data that were readily available as of the date of our request. We also reviewed available purchased care mental health appointment access data for the same time period. We compared the direct and purchased care mental health appointment data to access to care standards set in DOD policy.<sup>8</sup> We assessed the reliability of the mental health appointment data for the MHS's direct and purchased care systems by interviewing knowledgeable DOD and military service officials, reviewing supporting documentation, and reviewing the data for obvious errors or outliers; as a result, we determined that they were sufficiently reliable for the objectives of this report. We also examined whether the data and access to care standards used by DOD to assess mental health access are consistent with federal standards for internal control.<sup>9</sup>

To further examine the accessibility of MHS mental health care, we also obtained results for questions relevant to access to MHS mental health care from four recent surveys: (1) the fiscal year 2011-2014 Health Care Survey of DOD Beneficiaries; (2) the TRICARE Standard Survey of Civilian Providers for 2012 and 2013; (3) the TRICARE Standard Survey of Beneficiaries for 2012 and 2013; and (4) the 2013 Air Force

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<sup>7</sup>The TRICARE Operations Center electronically collects appointment process details for all MTFs and provides MTF clinical staff and decision makers at all levels access reports. The TRICARE Operations Center's Access to Care Mental Health Summary reports identify appointments related to mental health by using the International Statistical Classification of Diseases and Related Health Problems codes 291 through 319.99 for their analyses.

<sup>8</sup>DOD's TRICARE Policy for Access to Care also includes drive time and office wait time standards. For example, the standards require that acute and routine appointments be provided within 30 minutes travel time of the beneficiary's residence, while specialty appointments are to be provided within one hour travel time of the beneficiary's residence. Related to office wait times, the TRICARE policy includes an access standard of 30 minutes. This report focuses on the access standards specific to appointment wait times.

<sup>9</sup>GAO, *Internal Control: Standards for Internal Control in the Federal Government*, [GAO/AIMD 00 21.3.1](#) (Washington, D.C.: November 1999). Internal control is a process affected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

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Community Assessment survey.<sup>10</sup> Through reviews of survey-related documentation and interviews with relevant officials, and on the basis of our prior reviews of the two TRICARE Standard surveys, we assessed the reliability of the data from each of the four surveys and determined that they were sufficiently reliable for the purposes of this report. We also reviewed DOD and service documents, interviewed DOD and military service officials, and interviewed representatives from associations representing servicemembers and mental health providers.<sup>11</sup> Additionally, we reviewed relevant published literature related to MHS mental health access. For those studies included in this report, we reviewed the methods used in the studies and found them to be reasonable. Because DOD civilians are generally not entitled to MHS health care except when deployed or if they have a health condition determined to be related to their deployment, we did not include DOD civilians in our review of how accessible MHS mental health care is domestically and overseas.

To examine the availability and accessibility of mental health care for military servicemembers and DOD civilians in deployed settings, we interviewed DOD and military service officials and reviewed Mental Health Advisory Team (MHAT) reports that provide insight into the types of mental health care available in deployed settings such as Afghanistan. MHATs are small teams who deploy to combat environments and conduct surveys and focus groups of both servicemembers and providers. From 2003 to 2013, MHATs conducted studies on a mostly annual basis that examined the mental health care provided in Afghanistan and Iraq,

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<sup>10</sup>DOD also measures patients' satisfaction with access to care through its TRICARE Outpatient Satisfaction Survey, which is sent randomly to MHS beneficiaries following outpatient encounters with a MTF or civilian provider. However, a DOD official reported that this survey does not include any mental health specific questions and that DHA does not routinely separate the results of patients who had mental health visits from the rest of outpatient visits. The official said that the TRICARE Outpatient Satisfaction Survey would not be a promising source of mental health data. Therefore, we did not use it in conducting our work for this report.

<sup>11</sup>We interviewed representatives from the following associations: the American Psychiatric Association, the American Psychological Association, the Military Officers Association of America, and the Reserve Officers Association. We also interviewed the former Legislative Director of the National Guard Association of the United States.

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including the types of mental health care available in the deployed environment.<sup>12</sup>

We conducted this performance audit from July 2015 to April 2016 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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## Background

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### MHS Overview

The MHS operated by DOD has two missions: (1) supporting wartime and other deployments and (2) providing peacetime health care. In support of these two missions, DOD operates a large and complex health care system that employs more than 150,000 military, civilian, and contract personnel working in MTFs. DHA oversees the TRICARE health plan, and also exercises authority and control over the MTFs and subordinate clinics assigned to the NCR Medical Directorate. Outside of the NCR Medical Directorate, each military service operates its own MTFs and their subordinate clinics. Each military service recruits, trains, and funds its own medical personnel to administer medical programs and provide medical services to servicemembers. DHA does not have direct command and control of MTFs operated by the military services.

In the MHS, health care is provided at no cost to active duty military servicemembers through the TRICARE Prime health care option.<sup>13</sup> Reservists called or ordered to active service for more than 30 days have the same coverage as active duty servicemembers under TRICARE Prime, while inactive reservists may qualify to purchase TRICARE

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<sup>12</sup>The first study was mandated by the Army Surgeon General in 2003 and assessed Operation Iraqi Freedom-related mental health issues.

<sup>13</sup>The TRICARE program offers three basic options—TRICARE Prime (a managed care option), TRICARE Extra (a preferred provider organization option), and TRICARE Standard (a fee-for-service option)—as well as other options, such as TRICARE Reserve Select and TRICARE for Life, among others, to eligible beneficiary groups.

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Reserve Select (TRS) coverage.<sup>14</sup> The health care services covered by TRICARE Prime and TRS are generally the same, although the options vary by factors such as enrollment requirements, choices between civilian and MTF providers, required contribution from servicemembers toward the cost of care, and referral and prior authorization requirements.<sup>15</sup> Data from the end of fiscal year 2014 showed that there were 1,587,987 active duty servicemembers enrolled in TRICARE Prime and 121,912 reservists with TRS.

Within the United States, TRICARE is organized into three main regions—North, South, and West. (See fig. 1 for a map of the three regions.) DHA and TRICARE Regional Offices are responsible for managing purchased care through contractors in each of these regions. In each region, the contractor develops a network of civilian providers—referred to as network providers—to serve all the TRICARE beneficiaries in geographic areas called Prime Service Areas.<sup>16</sup> The TRICARE Regional Offices, in particular, are responsible for monitoring the quality and adequacy of contractors' provider networks and customer-satisfaction outcomes. Overseas, TRICARE is divided into three areas: Eurasia-Africa, Latin America and Canada, and Pacific. One contractor serves these areas, which is overseen by the TRICARE Overseas Office.

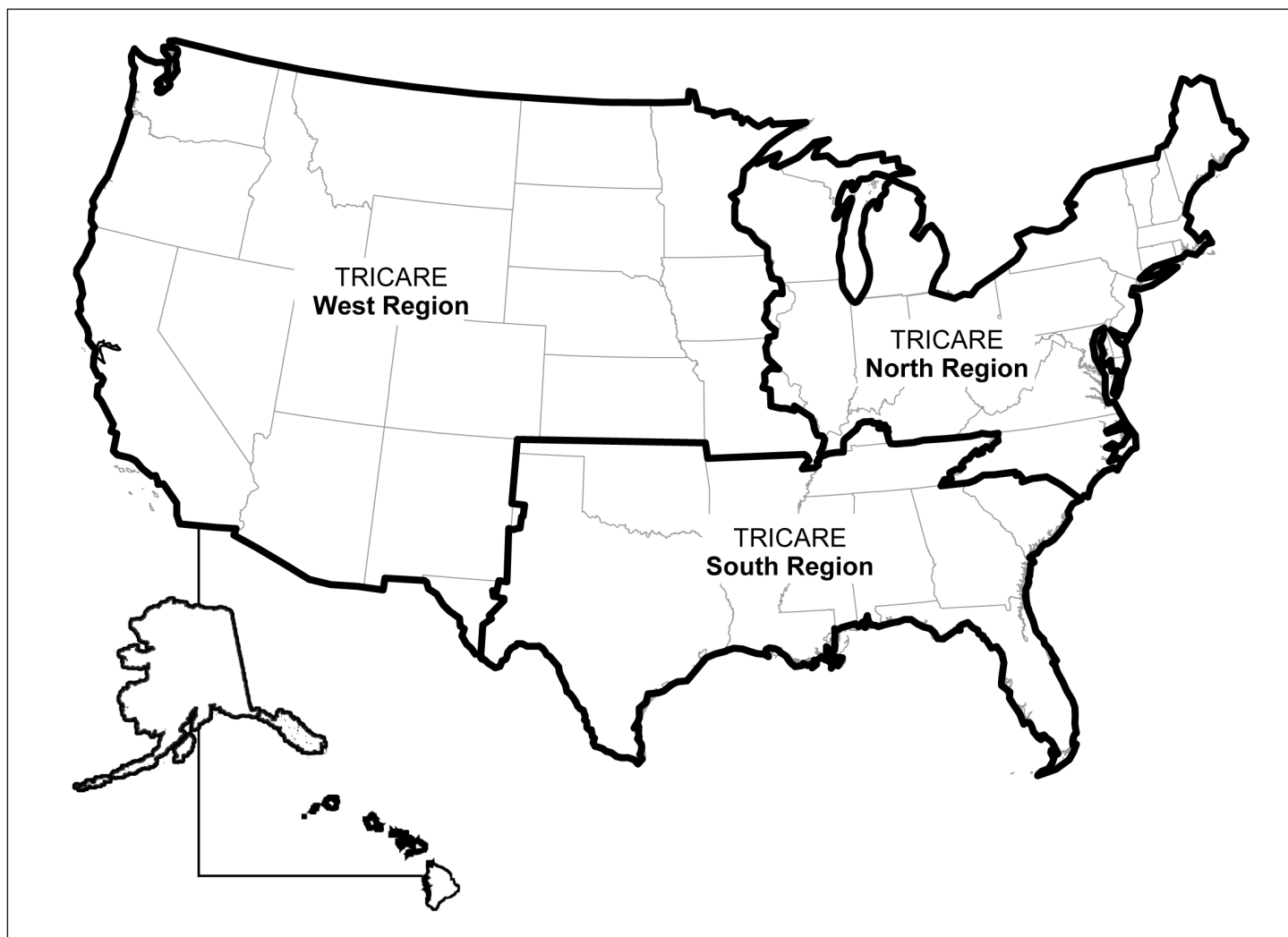
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<sup>14</sup>TRS is a premium-based health plan under which eligible reservists may obtain health care from both network or non-network civilian providers or from an MTF on a space-available basis. Eligible reservists have lower cost-sharing requirements when using network providers. To be eligible for TRS, the reservist must be a member of the Selected Reserve of the Ready Reserve and not eligible for or enrolled in the Federal Employees Health Benefits program, either under their own eligibility or through a family member who is enrolled in a family plan.

<sup>15</sup>By policy, all TRICARE enrollees may obtain care at MTFs, although priority is first given to any active duty servicemembers and reservists entitled to care relating to line-of-duty incurred conditions, followed by other enrollees in TRICARE Prime, such as active duty family members, and then to enrollees in other TRICARE plans like TRS.

<sup>16</sup>Prime Service Areas are geographic areas determined by the Assistant Secretary of Defense for Health Affairs and are defined by a set of five-digit zip codes, usually within an approximate 40-mile radius of an MTF.

**Figure 1: Location of TRICARE Regions in the United States**



Sources: GAO analysis of data from the Department of Defense; Map Resources (map). | GAO-16-416

## MHS Coverage Eligibility for Reservists and Deployed DOD Civilians

Reservists have a general cycle of coverage during which they are eligible for MHS care through various TRICARE options based on their duty status – preactivation, active duty, deactivation, and inactive. During preactivation, when reservists are notified that they will serve on active

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duty in support of a contingency operation for more than 30 days in the near future, they are eligible for TRICARE benefits as an active duty servicemember.<sup>17</sup> While on active duty for more than 30 days, reservists are required to enroll in TRICARE Prime and are eligible to receive the same medical services accorded to active-duty servicemembers.<sup>18</sup> During deactivation, reservists returning from more than 30 days of active duty in support of a contingency operation may be eligible for 180 days of transitional health care through various TRICARE options.<sup>19</sup> Inactive reservists can choose to purchase TRS coverage, if eligible, or use any other health coverage for which they may be eligible, such as employer-sponsored insurance. For reservists who are injured, become ill, or incur a disease while in a duty status, a line of duty determination is required and must be approved in order to determine eligibility for any MHS medical care associated with the specific injury, illness, or disease. If this determination is positive, the reservist is eligible to receive medical treatment for the specific injury, illness, or disease described in the line of duty determination through MTFs or civilian providers.

DOD's policies also entitle all deployed DOD civilian employees to medical treatment and services, including mental health services, at the same level and scope of those services provided to military personnel while in that deployed setting. Upon returning from deployment, DOD civilians are eligible to receive care in an MTF for any mental health

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<sup>17</sup>For reservists activated but not in support of a contingency operation, TRICARE Prime coverage becomes effective the date active duty starts. A contingency operation is a military operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force. It also includes any military operations that result in the retention of active duty servicemembers during a war or national emergency as declared by the President or Congress.

<sup>18</sup>National Guard personnel health eligibility is based on their military status as defined in Title 10 of the United States Code.

<sup>19</sup>Reservists activated but not in support of a contingency operation return to inactive status immediately after separating from active duty and are not eligible for transitional health care.



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conditions determined to be related to their deployment.<sup>20</sup> This care is provided at no cost. Formerly deployed DOD civilians with mental health conditions related to their deployment can also elect to get treatment outside an MTF and get their care reimbursed, or seek care through their regular health insurance if the health plan will cover the treatment.

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## DOD Access to Care Standards

DOD has established, in regulation and policy, TRICARE Prime access standards related to various aspects of DOD mental health care, including appointment wait times.<sup>21</sup> The standards include appointment wait time standards for four types of mental health appointments—acute, routine, wellness, and specialty (see table 1). DOD measures its compliance with these wait time standards in several ways, including monitoring the average number of days to be seen for each appointment type, as well as the average percentage of appointments that meet the relevant access standard.<sup>22</sup> The MHS goal is for 90 percent of appointments of each type to meet the relevant access standard. The standards apply to care delivered to TRICARE Prime beneficiaries in either direct care or purchased care. The policy notes that it applies to overseas locations to the extent practicable, but overseas locations often present unique circumstances. The access standards, however, do not apply to care delivered in deployed settings.

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<sup>20</sup>For a civilian to be deemed eligible, it must be determined, based on the civilian's application and medical evidence, that the medical condition resulted from personal injury sustained in the performance of duty during deployment. Under the Federal Employees' Compensation Act, any disability resulting from a war-risk hazard is generally deemed to have resulted from personal injury sustained while in the performance of duty, whether or not the employee was engaged in the course of employment when the disability occurred. 5 U.S.C. § 8102(b).

<sup>21</sup>See 32 C.F.R. § 199.17(p)(5).

<sup>22</sup>DOD reports that the "average days to be seen" is a weighted average of all appointments made over a month; the average is calculated for the mental health clinic, which is rolled into the average calculated for the MTF, the regional command, the service, and the overall direct care system.

**Table 1: TRICARE Prime Mental Health Appointment Wait Time Access to Care Standards**

Appointment type	Acute	Routine	Wellness <sup>a</sup>	Specialty
<b>Description</b>	Urgent care – a nonemergency illness for which medically necessary treatment is needed	An initial, self-referred request for a new mental health condition or exacerbation of a previously diagnosed condition for which intervention is required, but not urgent	Well-patient visit for health promotion and disease prevention	First specialty appointment for mental health care
<b>Wait Time Standard</b> (Time between appointment request and appointment date)	1 day or less	Within 7 calendar days	Within 28 calendar days	Within 28 calendar days

Source: GAO analysis of Department of Defense (DOD) policy. | GAO-16-416

<sup>a</sup>DOD officials reported that mental health wellness appointments might consist of periodic exams such as congressionally or DOD-mandated mental health exams. For example, DOD policy requires that mental health assessments be conducted at four different times for each servicemember deployed in connection with a contingency operation.

Within the MHS's direct care system, compliance with the access standards is monitored using appointment data available from DOD's Composite Health Care System, the electronic system through which patient appointments are booked. Appointments are scheduled in the system, which is programmed to count the actual waiting time between the date of the appointment request and the scheduled appointment date. These metrics are readily available at each MTF and at higher organizational levels, including service headquarters. DOD reports that oversight of appointment wait times and the availability of care for all clinics under the command of an MTF is a key responsibility of the leadership team at that facility and that ultimately, the MTF Commander is accountable for performance related to delays in care for all medical care, including mental health.

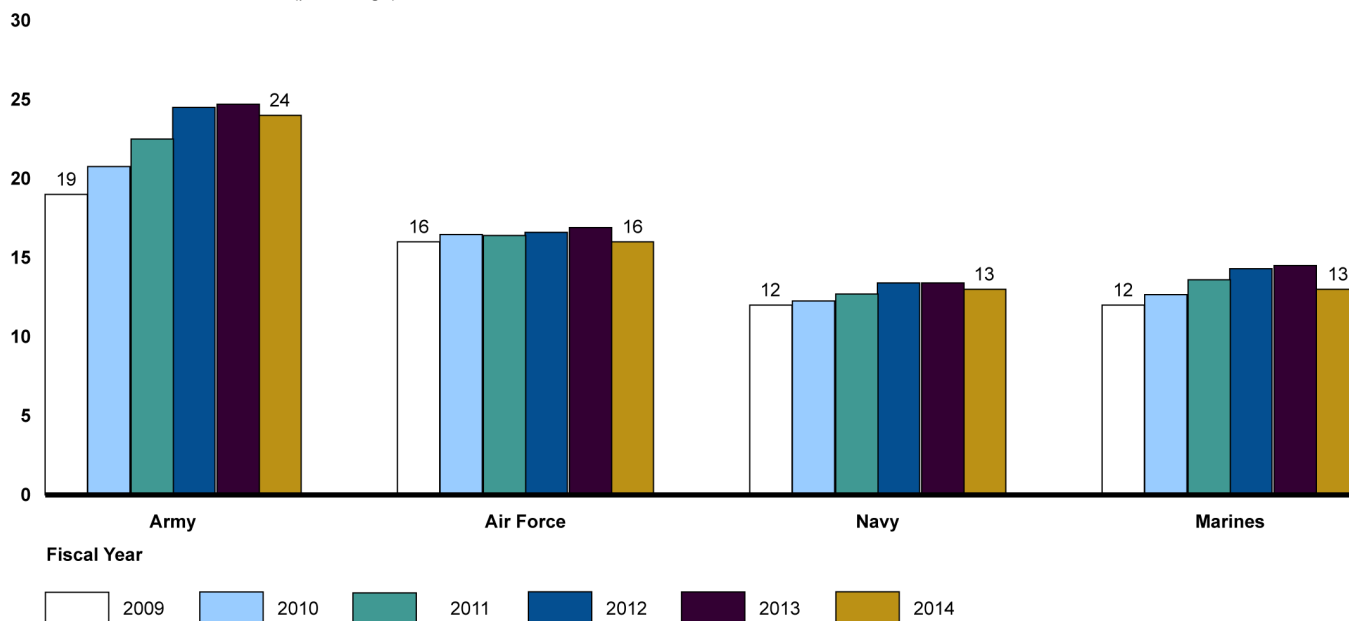
In the purchased care system, detailed data about compliance with DOD's access to care standards are not available; instead, patient satisfaction with the length of time to an appointment, as measured through TRICARE beneficiary surveys, is used as a surrogate measure of access. While the TRICARE regional contractors submit appointment data to DHA, the contractors do not collect and report the same level of detail on access to care as is available in the direct care system, and the contractors do not use the same information systems. Moreover, the overseas contractor does not collect the same data as the U.S. contractors.

## Utilization of MHS Mental Health Care

Use of MHS mental health care has generally increased among active duty servicemembers. From fiscal year 2009 through fiscal year 2013, the percentage of active duty servicemembers who used either outpatient or inpatient mental health care provided through DOD's MHS increased across all four services. Across all services, utilization began to decline in fiscal year 2014 (see fig. 2).

**Figure 2: Percentage of Active Duty Servicemembers Who Used Any Mental Health Care, by Service, Fiscal Years 2009 through 2014**

Utilization of mental health care (percentage)



Source: GAO analysis of Department of Defense Data. | GAO-16-416

Note: This data includes active duty servicemembers' and activated National Guard and Reserve servicemembers' utilization of any inpatient or outpatient mental health treatment service domestically and overseas through the direct care (military treatment facilities and clinics) or purchased care (civilian, non-Department of Defense providers) systems.

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## DOD Makes a Variety of Inpatient and Outpatient Mental Health Care Available Domestically and Overseas

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### DOD Offers a Variety of Mental Health Care Services

DOD makes a variety of mental health care services available both domestically and overseas to active duty servicemembers, ranging from outpatient services such as psychotherapy and telehealth, to inpatient services such as acute psychiatric care, as well as emergency services.<sup>23</sup> Table 2 lists the covered outpatient and inpatient mental health services available to servicemembers through the various TRICARE options. Army and Air Force officials stated the same mental health care is generally available domestically and overseas. While a TRICARE fact sheet notes that when overseas, limitations on mental health care services may apply, the Air Force reported that servicemembers are screened prior to overseas tours to minimize the likelihood of needing care that is not available. Army officials added that the availability of specific mental health services to be provided through direct care in a particular MTF or clinic depends on multiple factors, including the MTF's size and the mental health needs of the beneficiary population it serves. For example, not all MTFs offer inpatient mental health services. In such cases, an active duty servicemember requiring inpatient mental health services

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<sup>23</sup>Telehealth allows servicemembers to use secure audio-visual conferencing to have real-time, synchronous interaction with an off-site clinician who can provide assessment, diagnostic, and intervention services to eligible beneficiaries in order to increase access to care, decrease the need for travel, and deliver services to remote locations where traditional mental health services may not be available.

would either be referred to purchased care or travel to an MTF that offers such services.<sup>24</sup>

**Table 2: Examples of Mental Health Services Available to Servicemembers through TRICARE**

Inpatient services	Outpatient services
<ul style="list-style-type: none"><li>• Acute inpatient psychiatric care</li><li>• Psychiatric partial hospitalization</li><li>• Residential treatment facility care</li></ul>	<ul style="list-style-type: none"><li>• Applied behavior analysis</li><li>• Eating disorder therapy</li><li>• Medication management</li><li>• Psychological testing and assessment</li><li>• Psychotherapy</li><li>• Psychoanalysis</li><li>• Substance abuse treatment</li><li>• Telehealth program<sup>a</sup></li></ul>

Source: Department of Defense | GAO-16-416

<sup>a</sup>Telehealth allows servicemembers to use secure audio-visual conferencing to have real-time, synchronous interaction with an off-site clinician.

DOD Provides Most Outpatient Services through Direct Care and Most Inpatient Services through Purchased Care

In fiscal year 2014, DOD provided most of its outpatient mental health services through the direct care system, while providing most of its inpatient mental health services through the purchased care system. Among all of DOD's military services, outpatient mental health care is provided at nearly all MTFs and clinics, while inpatient mental health care is less widespread. For example, the Army reported that in fiscal year 2014, all of its 56 MTFs and clinics provided outpatient mental health care, whereas only 13, or 23 percent, of the Army's MTFs and clinics provided inpatient mental health care. For the same year, the Air Force reported all of its 75 MTFs with mental health clinics provided outpatient mental health services, but only 2 MTFs, or approximately 3 percent, provided inpatient mental health care. The Navy, which also provides

<sup>24</sup>Active duty servicemembers are required to seek nonemergency mental health care at military hospitals or clinics when available. If services are not available, active duty servicemembers must obtain referrals and prior authorizations from their primary care manager before receiving care through the purchased care system. All other TRICARE beneficiaries, including inactive reservists, may receive the first eight outpatient mental health care visits per fiscal year without a referral or prior authorization for a covered TRICARE benefit, such as psychotherapy, from the purchased care system. Prior authorization from the regional contractor is required beginning with the ninth outpatient mental health care visit per fiscal year.

health care services for the Marine Corps, reported that in fiscal year 2014, there were 67 MTFs and clinics that provided outpatient mental health care, whereas only 4 MTFs provided inpatient mental health care.

Consistent with the availability of outpatient mental health services at MTFs and clinics, about 76 percent of outpatient mental health encounters for active duty servicemembers were provided through direct care across all military services in fiscal year 2014 (see table 3).<sup>25</sup> In contrast, inpatient mental health care was provided mostly through purchased care in that year for all the military services except the Navy, which divided its provision of inpatient mental health care equally through direct care and purchased care.<sup>26</sup> DOD and Army officials reported that they have increasingly focused on providing mental health care through the direct care system—citing reasons such as a need for DOD and the services to be aware of active duty servicemembers’ mental well-being to assess both their fitness for duty and whether they pose any risk to themselves or others.

**Table 3: Provision of Mental Health Care for Active Duty Servicemembers through Direct and Purchased Care, Inpatient and Outpatient, by Service, Fiscal Year 2014**

	Percentage of care delivered by direct and purchased care systems			
	Outpatient care (in encounters)		Inpatient care (in bed days)	
	Direct <sup>a</sup> (%)	Purchased <sup>b</sup> (%)	Direct <sup>a</sup> (%)	Purchased <sup>b</sup> (%)
DOD-wide	76	24	31	69
Army	75	25	33	67
Navy	85	15	50	50
Air Force	67	33	14	86
Marines	79	21	29	71

Source: GAO analysis of Department of Defense data. | GAO-16-416

Note: The table shows the distribution of 2.94 million outpatient mental health encounters and 0.22 million inpatient mental health bed days for active duty servicemembers and activated National Guard and Reserve servicemembers in fiscal year 2014. Outpatient encounters included encounters for mental health care in a military treatment facility and any units of service for mental health care provided by a civilian provider. Inpatient care was measured as the number of bed days utilized either in a military treatment facility or in a civilian facility by a servicemember who had a mental health diagnosis.

<sup>25</sup>Outpatient encounters included encounters for mental health care in an MTF and any units of service for mental health care provided by a civilian provider.

<sup>26</sup>Inpatient care was measured as the number of bed days utilized either in a MTF or in a civilian facility by a servicemember who had a mental health diagnosis.

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<sup>a</sup>In the direct care system, medical care is provided through the Department of Defense's military treatment facilities and clinics.

<sup>b</sup>In the purchased care system, medical care is provided through networks of civilian health care providers.

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## Military Services Also Make Mental Health Care Available through Non-Traditional Methods

To address the mental health needs of servicemembers, the military services have integrated mental health providers in primary care settings, embedded mental health providers within units, and used telehealth. Each military service has established a program to integrate mental health providers into primary care settings to decrease overall health care costs and improve patient access to mental health services. A DOD official stated that these mental health providers, officially termed internal behavioral health consultants, are typically psychologists and social workers who help primary care providers with any mental health concerns that servicemembers have. As needed, the consultants also help servicemembers adhere to their treatment regimens. According to DOD, internal behavioral health consultants typically see patients one to four times for a 30-minute appointment per episode of care and refer them to specialty mental health care for a more intensive level of services if they show no improvement.

The number of behavioral health consultants varies across DOD's military services. Army officials stated that in fiscal year 2014, the Army had internal behavioral health consultants in 38 of its 56 MTFs and clinics. The officials reported that integrating internal behavioral health consultants into primary care settings has been an effective method to provide behavioral health care. The Air Force reported that as of fiscal year 2014, 71 of its 75 MTFs had internal behavioral health consultants. The Navy reported that as of fiscal year 2014, the service had placed internal behavioral health consultants in 71 clinics throughout the 27 domestic and overseas Naval MTFs, and has plans to eventually have them in 80 clinics.<sup>27</sup>

DOD's military services have also co-located mental health providers with units to provide an easy point of access to mental health care and to help destigmatize these services. For example, the Army uses Embedded Behavioral Health (EBH) teams, which are multidisciplinary teams of approximately 13 mental health providers and support staff who are

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<sup>27</sup>The Marine Corps does not operate any MTFs. The Navy provides health care services for the Marine Corps through its MTFs and clinics.

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stationed near servicemembers' units and barracks. In fiscal year 2014, the Army had 58 functional EBH teams that supported all of its combat brigade teams.<sup>28</sup> Air Force officials reported that the Air Force embeds mental health providers in units that remotely pilot aircraft, Special Operations units, and at one Air Force base.<sup>29</sup> In fiscal year 2014, the Air Force had 23 embedded mental health providers. The Navy uses both the Army's and the Air Force's approach, with embedded mental health teams stationed near servicemembers' units, as well as mental health providers co-located with units. The Navy embeds active duty mental health providers in all of its large seagoing platforms, in all Marine Corps infantry regiments, and in all Navy and Marine Corps Special Operations Commands.<sup>30,31</sup> In fiscal year 2014, the Navy had 19 locations with embedded mental health teams located near units and an additional 11 mental health providers stationed aboard its ships.

The military services have also implemented telehealth programs with varying degrees of complexity to leverage the services' existing resources and increase the availability of mental health care in areas with provider shortages.<sup>32</sup>

- The Army has a global multidisciplinary telehealth program, consisting of psychiatrists, psychologists, and other mental health providers, who provide mental health care to servicemembers in regionally-remote settings as well as in deployed settings. An Army official stated that the Army uses telehealth when an MTF reaches capacity,

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<sup>28</sup>The Army reports that a combat brigade comprises approximately 3,000 to 5,000 servicemembers.

<sup>29</sup>An Air Force official reported that the Air Force currently embeds mental health providers with their basic trainees in Lackland Air Force Base (San Antonio, TX) due to an occurrence of sexual assault and in response to other concerns about mistreatment of trainees at that particular location.

<sup>30</sup>According to a Marine Corps website, a regiment consists of several battalions, is led by a colonel, and comprises 2,700 to 3,600 servicemembers. The Marine Corps reported that it embeds mental health providers into Marine regiments. These providers are referred to as Operational Stress Control and Readiness providers.

<sup>31</sup>The Naval Special Warfare Command is the Navy's special operations force. The U.S. Marine Corps Special Operations Command and the Naval Special Warfare Command deploy worldwide in support of combatant commanders and other agencies.

<sup>32</sup>However, Guard and Reserve officials reported that there are no telehealth programs for reservists.



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supplementing that MTF's delivery of care with telehealth services instead of using the purchased care or requiring the servicemember to wait to receive care. The same official noted that the Army is looking to use its telehealth program to support administrative evaluations in addition to providing mental health treatment.

- The Air Force uses telehealth to provide psychiatry services to smaller isolated bases. Air Force officials reported that their telehealth program consists of 9 staff, including 5 psychiatrists who use video teleconferencing to support MTFs that do not have an on-site psychiatrist and 2 psychologists who primarily assist with completing administrative evaluations.
- The Navy Medicine telehealth program office has begun telehealth services at several Navy health care facilities and is developing plans for its systematic use. Navy officials reported that the Navy used telehealth on an ad hoc basis in the past to provide mental health care at installations that did not have access to mental health providers.

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### DOD Has Increased the Number of Available Mental Health Providers, but DOD Data Show Shortages for Some Provider Types

Our analysis of DOD staffing data for the direct care system from fiscal years 2009 through 2015 and for the purchased care system from December 2010 through July 2015 shows that DOD increased the number of available mental health providers in both delivery systems, thereby increasing DOD's mental health capabilities to meet servicemembers' mental health care needs. In its direct care system, DOD increased the number of mental health providers by 15 percent—from 4,608 providers to 5,276 providers—from fiscal year 2009 through fiscal year 2015.<sup>33</sup> This increase was in response to the NDAA for Fiscal Year 2010, which required the Secretary of each military service to increase the number of active duty mental health personnel authorized for the service.<sup>34</sup> Of the three military services, the Army and Air Force increased their mental health provider staffing from fiscal year 2009 through fiscal year 2015. The Army's addition of 467 mental health providers, from 2,721 in fiscal year 2009 to 3,188 in fiscal year 2015, was the largest increase among the military services. In contrast, the Navy

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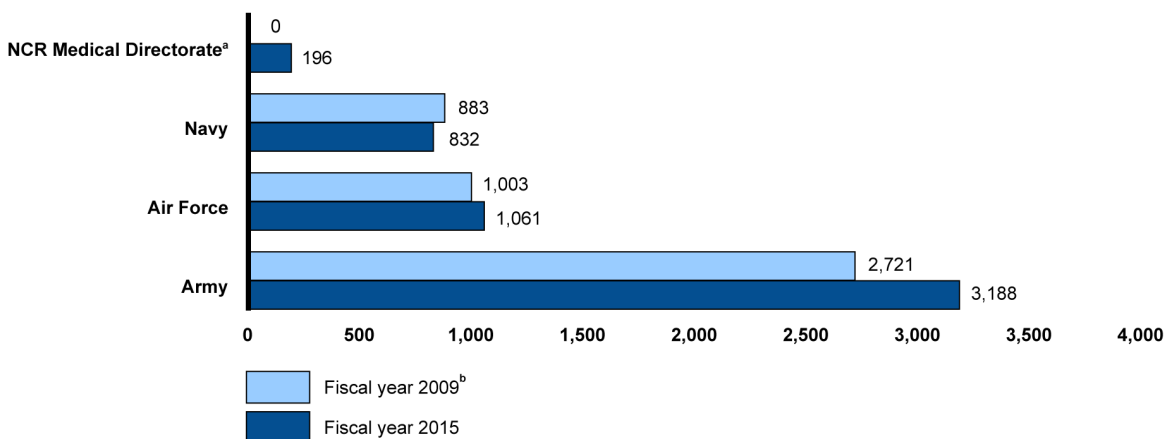
<sup>33</sup>Mental health provider totals in this report have been rounded to the nearest full-time equivalent. Fiscal year 2009 mental health provider totals include mental health registered nurses, because in that year their numbers were reported along with mental health nurse practitioners and could not be separated out from the data DOD provided.

<sup>34</sup>See Pub. L. No. 111-84, § 714(a), 123 Stat. 2190, 2381 (2009). As used in this report, an authorized position refers to a position that the DOD component has approved for funding for a specific fiscal year.

decreased its staffing by 51 mental health providers, from 883 in fiscal year 2009 to 832 in fiscal year 2015 (see fig. 3).<sup>35</sup>

**Figure 3: Total Department of Defense (DOD) Mental Health Providers by Military Service and the National Capital Region (NCR) Medical Directorate, September 2009 and September 2015**

Number of providers by military service



Source: GAO analysis of DOD data. | GAO-16-416

<sup>a</sup>In fiscal year 2009, all civilian and contract mental health providers assigned to the military treatment facilities (MTF) and subordinate clinics that are now within the NCR Medical Directorate were included in the military service totals, because at that time all MTFs within the NCR Medical Directorate were managed by multiple military services. In fiscal year 2015, the NCR Medical Directorate reported its own civilian and contract mental health provider totals while retaining military mental health providers within the appropriate military services' figures.

<sup>b</sup>Fiscal year 2009 mental health provider totals include mental health registered nurses because in that year their numbers were reported along with mental health nurse practitioners and could not be separated out from the data DOD provided.

Despite the general increase in the available MHS mental health providers, shortages for certain types of mental health providers, such as psychiatrists and social workers, have persisted (see fig. 4).<sup>36</sup> For example, DOD staffing data show that by the end of fiscal year 2015, all of the military services had a shortage of psychiatrists, with 127 positions authorized but not filled. In addition, both the Navy and the Air Force had

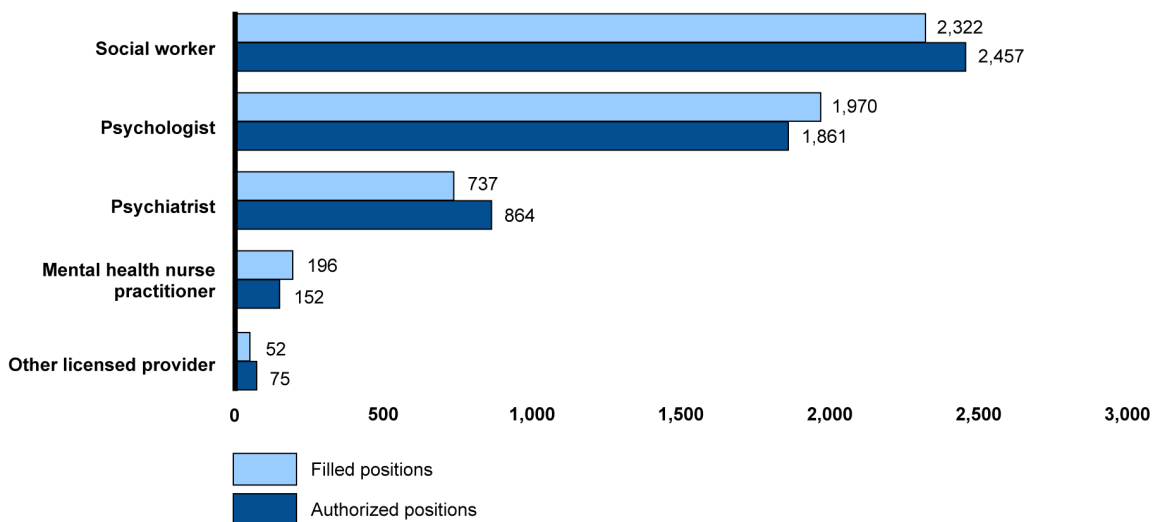
<sup>35</sup>The Navy provides health care services for the Marine Corps, and any Marine Corps mental health providers are included in Navy data.

<sup>36</sup>We defined shortages as the difference between the number of authorized positions and the number of assigned, or on-board, providers. DOD refers to this as a staffing gap differential.

more authorized positions for every type of mental health provider, except mental health nurse practitioners, than were filled. (See app. 1 for more information on service-level staffing shortages in fiscal year 2015.) We previously found that the military services believed that a nationwide shortage of mental health professionals, as well as overarching military-specific challenges such as frequent deployments and relocations and competitive compensation, have adversely affected DOD's ability to recruit and retain mental health providers.<sup>37</sup>

**Figure 4: Filled and Authorized Mental Health Positions across the Department of Defense (DOD), by Provider Type, September 2015**

Number of providers by type



Source: GAO analysis of DOD data. | GAO-16-416

Notes: As used in this report, an authorized position refers to a position that the DOD component has approved for funding for a specific fiscal year. In fiscal year 2015, there were more filled positions of mental health nurses and psychologists in DOD than were authorized. This difference was driven by the Army. Army officials explained that this was due to their practice of hiring staff according to need and subject to funding availability rather than authorizations.

<sup>37</sup>See GAO, *Defense Health Care: Additional Information Needed About Mental Health Provider Staffing Needs*, [GAO-15-184](#) (Washington, D.C.: Jan. 30, 2015). In [GAO-15-184](#), our calculations of mental health provider staffing changes included mental health registered nurses. However, in April 2016, DOD told us that it does not consider mental health registered nurses to be mental health providers. Therefore, mental health registered nurses have been excluded, when possible, from our analysis of mental health provider staffing changes.

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In the purchased care system, two of the three domestic TRICARE managed care contractors increased the number of available network mental health providers in Prime Service Areas, which are geographic areas usually within an approximate 40-mile radius of an MTF.<sup>38</sup> Network providers are those civilian providers who have a contractual relationship with the TRICARE managed care contractor to provide care at a negotiated rate. From December 2010 to July 2015, the total number of network mental health providers increased by 7,887 providers (52 percent increase), from 15,216 in December 2010 to 23,103 in July 2015, in the TRICARE North region. During the same time period, the total number of network mental health providers increased by 39,025 providers (190 percent increase), from 20,515 in December 2010 to 59,540 in July 2015, in the TRICARE West region. In contrast, from December 2011 to July 2015, the total number of network mental health providers in the TRICARE South region decreased by 2,149 providers (17 percent decrease), from 12,505 in December 2011 to 10,356 in July 2015 (see fig. 5).<sup>39</sup> An official from the TRICARE South contractor stated that while the number of network mental health providers in Prime Service Areas showed a decrease, the South region over this time period had an overall increase in mental health providers (if providers outside Prime Service Areas are also included). The official added that despite the decrease, the number of providers contracted was more than sufficient to meet the demand in the vast majority of areas throughout the South region.<sup>40</sup>

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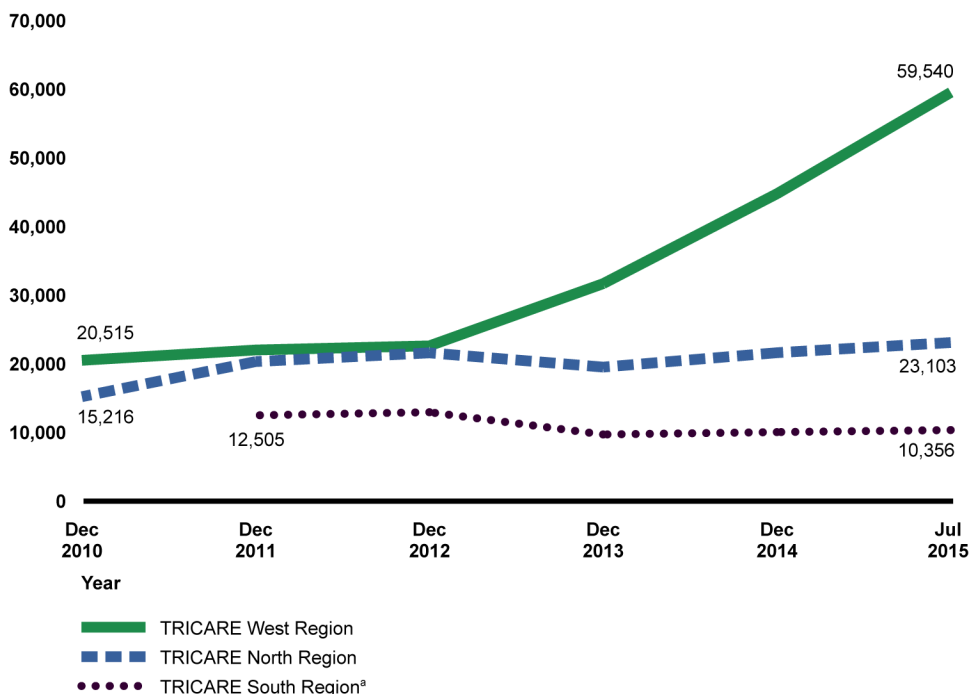
<sup>38</sup>Data on the number of mental health providers in the TRICARE Overseas areas are not available. An official from the TRICARE Overseas Office noted that there are no provider targets for the overseas areas because of differences in each location.

<sup>39</sup>TRICARE South region officials could not provide us with data for December 2010.

<sup>40</sup>The contractual requirements for the contractor network state that "the network, or networks, shall be sufficient in number, mix and geographic distribution of fully qualified providers to provide the full scope of benefits for which all PRIME enrollees are eligible under this contract."

**Figure 5: TRICARE Network Providers in Prime Service Areas, by TRICARE Region, December 2010 to July 2015**

Number of mental health providers by TRICARE region



Source: GAO analysis of Department of Defense data. | GAO-16-416

Note: Prime Service Areas are geographic areas determined by the Assistant Secretary of Defense for Health Affairs and are defined by a set of five-digit zip codes, usually within an approximate 40-mile radius of a military treatment facility.

<sup>a</sup>The TRICARE South Region could not provide data for December 2010.

Despite the general increase in mental health providers in the purchased care system, DOD data show that from December 2010 to July 2015 provider shortages, particularly for psychiatrists, persisted for certain Prime Service Areas in all three regions (e.g., Fort Riley, KS; Ft Polk, LA; Traverse City, MI).<sup>41</sup> The provider shortages were more prevalent in the TRICARE West Region, with up to 15 percent of Prime Service Areas

<sup>41</sup>We defined a TRICARE regional provider shortage as any Prime Service Area with fewer psychiatrists and other behavioral health providers contracted into the network than were targeted. The regional contractors stated that they use proprietary sizing models that estimate the number of targeted providers for each Prime Service Area based on a variety of inputs that include beneficiary population, enrollment data, and eligibility data.

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contracting fewer psychiatrists than targeted and up to 11 percent of Prime Service Areas contracting fewer behavioral health providers than targeted for the network in certain years.<sup>42</sup> In spite of the general decrease in contracted network mental health providers from December 2011 to July 2015 in the TRICARE South Region, the region had the fewest psychiatrist and behavioral health provider shortages, with no more than 6 percent of Prime Service Areas experiencing psychiatrist shortages, and no more than 2 percent of Prime Service Areas experiencing behavioral health provider shortages during this time period. Officials from the TRICARE South contractor told us that these shortages were possibly due to shortages of psychiatrists, particularly child psychiatrists, both at the national and local levels. TRICARE Regional Office officials told us that the contractors were limited in their ability to address these provider shortages because the provider shortages affect the entire health system and are not specific to the TRICARE program.<sup>43</sup>

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**MHS Mental Health Care Available to Inactive Reservists is Generally Limited to Assessments and Referrals or to Care Purchased through TRICARE Reserve Select**

Unlike the mental health care made available to active duty servicemembers, DOD generally does not make mental health care available to inactive reservists at no cost to them. While active duty servicemembers have access to a range of mental health care services provided at no cost to the servicemembers through TRICARE Prime, officials from the various Guard and Reserve components of DOD's military services told us that DOD generally does not make such mental health care available to inactive reservists—with the exception of conducting mental health assessments and referring reservists to community resources. Reservists who purchase TRS have access to the list of covered inpatient and outpatient services available through TRICARE. However, National Guard officials stated that the premiums, co-pays, and deductibles associated with seeking treatment would not be affordable for some reservists, particularly those of lower ranks and for

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<sup>42</sup>TRICARE regional office officials reported that behavioral health providers include psychologists, social workers, and alcohol and drug counselors.

<sup>43</sup>According to the Department of Health & Human Services' (HHS) Substance Abuse and Mental Health Services Administration, the nation faces a current shortage in the mental health and addiction services workforce, and that shortage is expected to continue. As of July 2015, there were about 4,000 areas designated as having a shortage of mental health professionals, which HHS's Health Resources and Services Administration projected would require almost 2,700 additional mental health providers to fill the need in these underserved areas.

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whom the Reserve or Guard is the sole source of employment. DOD reports that as of June 2014, about 25 percent of the reservists eligible to participate in TRS were enrolled.

Regarding the assessment and referral services available to inactive reservists, service officials reported that these services are provided through Directors of Psychological Health (DPH), who are typically licensed mental health providers, and who are responsible for developing community resource guides and cultivating community contacts that can provide either free or discounted mental health care to inactive reservists.<sup>44</sup> The Air and Army National Guard DPH programs are different in certain respects.

- **Air National Guard.** An Air National Guard official stated that as of July 2015, the Air National Guard had 93 DPHs who were embedded in 89 Air Force wings, with another 8 national staff who supported the DPHs in individual states.<sup>45</sup> The official stated that Air National Guard servicemembers have more in-person, face-to-face interactions with their DPHs by virtue of the DPHs being embedded with the units.
- **Army National Guard.** A National Guard Bureau official stated that as of July 2015, the Army National Guard had 157 DPHs. An Air National Guard official reported that unlike Air National Guard DPHs, Army National Guard DPHs may have dual status (for example, as a guardsman on the weekend and a clinical psychologist during the week), and those DPHs can therefore be deployed along with their units, leaving the Army National Guard with the challenge of finding a replacement to serve reservists remaining in their state.

In addition to the general DPH role to assess and refer reservists to community mental health resources, Air Force Reserve DPHs can also provide some clinical services, according to an Air Force Reserve official. The official told us that the Air Force Reserve DPHs are clinical social workers who are licensed, credentialed, and privileged to work in military hospitals and clinics. The same official stated that while these DPHs provide referrals and are mostly engaged in prevention efforts, the DPHs can provide some clinical services for reservists, which are then

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<sup>44</sup>An Army Reserve official stated that Army Reserve DPHs conduct screenings rather than assessments, which he said were not as comprehensive as assessments.

<sup>45</sup>Wings are defined as a level of command within the Air Force. The Air Force has three basic types of wings: operational, air base, and specialized mission.

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documented as such in the reservists' electronic medical records. An Air Force Reserve official noted that as of August 2015, there were 30 DPHs embedded in wings where the Air Force Reserve saw the greatest need, and the official said that the Air Force Reserve is likely to get additional DPHs in the future.

A Navy official stated that the Navy and Marine Corps Reserve Psychological Health Outreach Program teams, in their roles as DPHs, have instituted a Resiliency Check-In program that provides Navy and Marine Corps reservists with check-in screenings with a mental health provider, information on local community mental health resources, and case management as needed following the screening. The official, who is responsible for the psychological health of Navy and Marine Reserve Forces, credited the program with helping destigmatize mental health care. According to the official, these 12 regionally embedded Psychological Health Outreach Program teams are composed of 4-5 licensed mental health professionals led by regional DPHs who service all of the Navy and Marine Corps Reserve sites using various forms of communication and annual site visits.<sup>46</sup> For each Resiliency Check-In event, the teams typically schedule a minimum 15-minute appointment with each reservist to screen for psychological health and other needs. If a reservist is found to be in need of mental health care or have other needs that can impact the reservist's psychological health or unit, the teams provide the reservist with information detailing local health care resources; the teams also follow-up with the reservist for as long as needed.

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<sup>46</sup>An official with the Navy Medicine responsible for the psychological health of Navy and Marine Reserve forces stated that the 12 Psychological Health Outreach Program teams are embedded regionally within the Navy and Marine Corps Reserve Commands and serve all of the more than 120 Navy Reserve and 160 Marine Reserve commands. The official noted that these teams may visit a site more than once a year if needed, a decision influenced by the teams' travel budget resources, whether a command is preparing for a deployment or has suffered a loss due to suicide, or if there are special requests from the Command.



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## While DOD Met Most of Its Mental Health Appointment Access Standards, DOD Lacks a Key Standard, and Its Surveys Suggest Potential Access Problems

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### Recent Data Show That DOD Generally Met Its Access Standards for Most Direct Care Mental Health Appointment Types

Data from DHA's TRICARE Operation Center for April 2014 through August 2015 showed that MHS-wide, for appointments by active duty servicemembers in the direct care system, the mental health access to care standards were generally met for all domestic and overseas appointment types except routine appointments. The data come from Access to Care Mental Health Summary reports, which measure access both in terms of the average percentage of appointments that met the relevant access standard and the average number of days to be seen.<sup>47</sup> The data show that in terms of the percentage of domestic and overseas mental health appointments that met the access standard each month between April 2014 and August 2015, on average 96 percent or more of specialty and wellness appointments met the 28-day standard, exceeding the MHS goal of 90 percent (see table 4).<sup>48</sup> For acute appointments, more

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<sup>47</sup>DOD officials told us that the user communities for these reports include all levels of organizational leadership, including DOD-level users such as a TRICARE Operation Center working group and a DOD access improvement working group, and MTF staff such as clinic managers and schedulers. DOD notes that the medical staff at MTFs receive training in the use of TRICARE Operations Center reports to ensure that tools like the Mental Health Access to Care Summary report are understood and utilized.

<sup>48</sup>Examining overseas data separate from domestic data showed that even higher percentages of overseas mental health appointments met the access standards. For example, on average more than 90 percent of overseas routine appointments for active servicemembers in both the Air Force and the Navy met the 7-day standard for routine appointments between April 2014 and August 2015, while an average of 59 percent of the Army's overseas routine appointments met the standard. Overseas appointments represented less than 2 percent of the total MHS mental health appointments for these four appointment types during this time period.

than 90 percent of all three services' appointments met the 1-day standard on average; however, only 79 percent of NCR Medical Directorate acute appointments met the standard. For routine appointments, only the Air Force exceeded the 90 percent goal. Less than half of the Army routine appointments on average met the 7-day standard.

**Table 4: Average Percentage of the Military Health System's (MHS) Direct Care System Mental Health Appointments that Met the Access Standard, by Appointment Type, April 2014 through August 2015**

	Acute	Routine	Wellness	Specialty
MHS-wide	92%	59%	99%	97%
Air Force	92%	91%	100%	99%
Army	93%	44%	98%	97%
Navy <sup>a</sup>	91%	62%	99%	96%
National Capital Region Medical Directorate	79%	55%	99%	96%

Source: GAO analysis of Department of Defense data. | GAO-16-416

Notes: The data above only include appointments for active duty servicemembers and activated National Guard and Reserve servicemembers. Data for both domestic and overseas appointments are included. The TRICARE Operations Center identified mental health appointments using the International Statistical Classification of Diseases and Related Health Problems codes 291 through 319.99 for their analyses. MHS averages also include a small number (about one percent of total appointments) of Coast Guard appointments.

<sup>a</sup>Navy appointment data also include appointments for the Marine Corps.

In terms of average days to be seen, MHS-wide specialty and wellness appointments met the 28-day standard by a wide margin, averaging about 11 and 10 days to be seen, respectively (see table 5). There was more variability in terms of meeting the 1-day standard for acute appointments. Specifically, the Air Force and the Army met the standard from April 2014 through August 2015, but the Navy and the NCR Medical Directorate did not meet the standard—averaging 1.67 and 1.79 days to be seen, respectively. For routine appointments, only the Air Force met the 7-day standard in terms of average days to be seen, and both the Army and the NCR Medical Directorate more than doubled the desired days to a routine appointment.

**Table 5: Average Days to be Seen for Mental Health Appointments in the Military Health System's (MHS) Direct Care System, by Appointment Type, April 2014 through August 2015**

	Acute	Routine	Wellness	Specialty
Access standard	1 day or less	Within 7 days	Within 28 days	Within 28 days
MHS-wide	0.98	11.63	10.27	11.04
Air Force	0.66	4.67	9.79	9.87
Army	0.78	14.57	11.62	11.00
Navy <sup>a</sup>	1.67	12.16	7.98	11.19
National Capital Region Medical Directorate	1.79	18.17	8.68	12.42

Source: GAO analysis of Department of Defense data. | GAO-16-416

Notes: The data above only include appointments for active duty servicemembers and activated National Guard and Reserve servicemembers. Data for both domestic and overseas appointments are included. The TRICARE Operations Center identified mental health appointments using the International Statistical Classification of Diseases and Related Health Problems codes 291 through 319.99 for their analyses. MHS averages also include a small number (about 1 percent of total appointments) of Coast Guard appointments.

<sup>a</sup>Navy appointment data also include appointments for the Marine Corps.

We also examined routine appointment access in terms of the average days to the third next available appointment, another measure of access that is prospective rather than retrospective, and which DOD officials suggested may be a more accurate representation of appointment availability.<sup>49</sup> Data for the average number of days to the third next available routine appointment showed that the military services also did not meet the 7-day routine appointment access standard from April 2014 through August 2015 using this measure, with an MHS average of about 11 days to the third next available routine appointment. (See table 6.)

<sup>49</sup>In its 2014 Military Health System Review, DOD notes that both HHS's Agency for Healthcare Research and Quality and the Institute for Healthcare Improvement, an independent nonprofit, recommend measurement of the average number of days to third next available appointments as a more sensitive measure of access to care. The Institute for Healthcare Improvement notes that the third next available appointment is considered a more accurate assessment of actual appointment availability, rather than an opening due to a cancellation or acute event.

**Table 6: Average Days to the Third Next Available Routine Mental Health Appointment in the Military Health System's (MHS) Direct Care System, April 2014 through August 2015**

Access standard	Within 7 days
MHS-wide	11.1
Air Force	10.2
Army	11.6
Navy <sup>a</sup>	12.7
National Capital Region Medical Directorate	13.8

Source: GAO analysis of Department of Defense (DOD) data. | GAO-16-416

Note: DOD identified mental health appointments using the clinic codes for mental health clinics with the MHS direct care system.

<sup>a</sup>Navy appointment data also include appointments for the Marine Corps.

Although the mental health appointment access data suggest that DOD is not meeting the 7-day standard for routine appointments, officials suggested that these data are misleading, as some appointments were coded incorrectly—negatively impacting the routine appointment access results. For example, DOD, Navy and NCR Medical Directorate officials attributed the large numbers of days to routine appointments, in part, to a known technical problem in DOD's Composite Health Care System, which is used to book appointments. Officials said that this resulted in non-routine mental health appointments that were averaging about 15 days to be seen being mistakenly booked as routine—driving up the average days to routine appointments. In February 2016, DOD officials reported that a fix to this technical problem in the appointment booking system was underway and that the services had developed and disseminated specific guidance for booking clerks on the issue of incorrect appointment type categorization.

Additionally, Army officials said that a particular type of mental health treatment might be negatively impacting the Army's performance against the access standard for routine appointments; about one-third of routine appointments were for an intensive outpatient program which has scheduled start dates, such as the first Monday of the month. An Army official noted that while these appointments were booked as routine, the planned start date for the program may not occur for two weeks after booking. Another Army official noted that categorizing these appointments as routine may be a misapplication of the routine appointment category. An Army official said that as of December 2015 Army officials had begun discussions internally about standardizing the coding for these appointments.

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Nonetheless, a DOD official also said that the routine appointment data suggested that there may not be enough routine appointments available to meet demand, and that to resolve the access performance issue mental health clinics might need to make more routine appointments available on their schedules. The official suggested that because access data show that other types of mental health appointments, such as specialty appointments, are being scheduled well within the MHS standard timeframe of 28 days, mental health clinic appointment schedules should possibly be revised to allocate more routine appointments. However, in February 2016 DOD officials reported that until the issue of incorrectly coded appointments in the Composite Health Care System was resolved, the officials were limited in their ability to determine the extent to which a shortage of mental health appointments exists.

In addition to the factors mentioned above, NCR Medical Directorate officials also reported that difficulty recruiting and hiring qualified clinicians had affected their ability to deliver timely care to their patient population, but they were taking steps to improve access. Officials reported that ongoing enhancements to their staffing, referral, and appointing processes, as well as care delivery options, such as telehealth, were intended to improve access performance. NCR Medical Directorate officials said that MTF directors and commanders meet at least monthly to review progress in this area.

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### DOD Lacks an Access Standard for the Most Common Type of Direct Care Mental Health Appointment

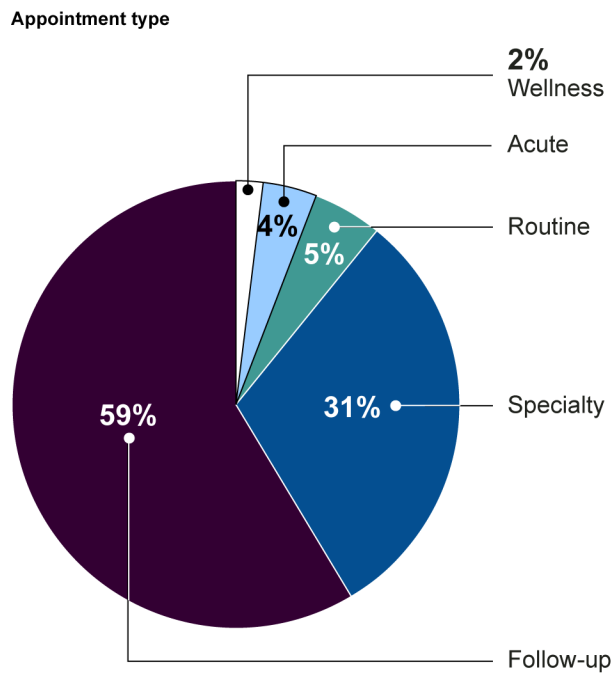
Although DOD has established standards and is monitoring access for four types of mental health appointments, DOD told us that most mental health appointments provided in the MHS's direct care system fall into a fifth category—follow-up appointments—which generally do not have an official DOD access to care standard.<sup>50</sup> A DOD official said that acute, routine, wellness, and specialty appointment categories are generally to be used only for a patient's initial referral or assessment for mental health care and that additional follow-up appointments for counseling, for instance, would fall into this fifth appointment category, which are coded

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<sup>50</sup>DOD reported that the agency has established access standards and measurement strategies for inpatient follow-up mental health care at 7 days and 30 days following a hospitalization for mental illness. The Army also noted that an Army policy also requires that soldiers be seen within 72 hours of an inpatient discharge, and that DOD tracks these follow-up appointments.

as ‘future’ appointments. Of the more than 2.6 million direct care mental health appointments that were scheduled from April 2014 through August 2015, about 59 percent were follow-up appointments (see fig. 6).

**Figure 6: Percentage of Total Military Health System (MHS) Direct Care Mental Health Appointments, by Appointment Type, April 2014 through August 2015**



Source: GAO analysis of Department of Defense data. | GAO-16-416

Notes: The data above only include appointments for active duty servicemembers and activated National Guard and Reserve servicemembers. Data for both domestic and overseas appointments are included. The Department of Defense identified mental health appointments using the clinic codes for mental health clinics within the MHS direct care system.

Regarding the lack of an access standard for follow-up appointments, a DOD official said that unlike the other appointment types, an access standard for follow-up appointments was not established in regulation, and that follow-up appointments generally do not have an official access standard against which they are measured. However, data are available from the Composite Health Care System through which DOD could monitor follow-up appointment access. Federal standards for internal control note that control activities need to be established and reviewed to monitor performance measures and indicators, and that these controls

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could call for comparisons and assessments relating different sets of data to one another so that analyses of the relationships can be made and appropriate actions taken.<sup>51</sup> By not establishing, reviewing, and monitoring an official performance standard for follow-up appointments—the most common mental health appointment type—DOD is missing performance information for the majority of the mental health care it provides.

Unlike DOD, some health care systems have established access standards and measurement strategies for follow-up mental health care. For example, the Veterans Health Administration's policy is that follow-up care for established veterans should be provided within 30 days of the clinically indicated date. In addition, a 2012 report from the Department of Veterans Affairs Office of Inspector General noted that the private sector health care organizations they studied measured follow-up appointments by establishing a pre-determined average number of visits (e.g., four) within the first 45–60 days of an initial new patient appointment, and they also measured the length of time between subsequent visits (e.g., the amount of time until the second, third, and fourth visits).<sup>52</sup>

DOD officials said that DHA is in the process of improving its oversight and monitoring of access to mental health care, although it did not report plans to develop an access standard for follow-up appointments. A DOD official noted that while there is not currently a DHA-led governance structure to conduct monthly assessments of access to care in specialty care (including mental health), there will be one in the future that mirrors the already established primary care monitoring structure.<sup>53</sup> The official noted that a newly formed advisory board had been established to optimize specialty care, evaluate performance, and make recommendations for continuous process improvement, and another official noted that under this advisory board, a Mental Health Working

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<sup>51</sup>See [GAO/AIMD 00 21.3.1](#).

<sup>52</sup>Department of Veterans Affairs, Office of Inspector General, *Veterans Health Administration: Review of Veterans' Access to Mental Health Care*, 12-00900-168 (Apr. 23, 2012).

<sup>53</sup>DOD reports that in primary care, a DHA-level governance structure has been created through which access performance mean, median, variance, and outliers are monitored quarterly. The services are responsible for taking corrective action at MTFs and clinics within MTFs that are outliers and do not meet access standards.

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Group had been chartered. That group has developed a mental health strategic plan—slated for implementation by the end of fiscal year 2016—which contains goals and initiatives related to improving access performance, including the standardization of business processes across all three services and the NCR. As part of its effort to standardize business processes, the Mental Health Working Group is proposing a revision to current coding practices, which it hopes will allow for greater surveillance and the ability to intervene and incentivize compliance with access standards. Additionally, the strategic plan contains an initiative related to identifying benchmarks for access, which is scheduled to be completed by the third quarter of fiscal year 2016. Nonetheless, DOD officials did not indicate that developing an official access standard for follow-up appointments would be part of the strategic planning process.

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Limited Data on Mental Health Access in Purchased Care Are Available, but DOD Instead Relies on Beneficiary Surveys and Complaints to Monitor Access

Limited data are available regarding access to care in the MHS's purchased care system. As previously mentioned, in lieu of detailed access to care compliance data, patient satisfaction with length of time to appointment, as measured through beneficiary surveys described later in this report, is used as a surrogate measure of access. In addition to beneficiary surveys, TRICARE Regional Office officials told us that they generally rely on beneficiary reports of access concerns, rather than on appointment wait time data. The officials said that all such reports are investigated and researched, and corrective action is taken when possible. A consultant that reviewed access in the MHS's purchased care system noted that these methods of monitoring compliance with access standards—beneficiary surveys and monitoring of beneficiary complaints—were consistent with the primary methods used by civilian health plans, even though the methods are not consistent with the direct-care system's focus on appointment wait time data.<sup>54</sup> The consultant also found that developing automated systems to better monitor wait times in purchased care was neither practical nor feasible, given the dispersed networks of providers that make up the purchased care system.

Nonetheless, in all three domestic TRICARE regions the 28-day mental health appointment access standard for specialty appointments is

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<sup>54</sup>Following the 2014 Military Health System Review, DOD commissioned a consultant to review access standards in purchased care, and whether the TRICARE managed care contractors could provide data that documents compliance with DOD's access standards. The consultant issued its final report in January 2015.



monitored for a servicemember's first mental health appointment that is referred to purchased care.<sup>55</sup> The wait time is measured as the time between a referral authorization and the first specialty service date reported on associated claims. While this measure may overstate the time to care because it does not account for factors such as the time a servicemember may take after receiving a referral authorization before calling for an appointment, the measure appears to be the best available proxy for monitoring compliance with this standard, according to the consultant that reviewed access in the MHS's purchased care system. Data provided by each TRICARE Regional Office showed that the three regions did not meet the MHS goal of having 90 percent of appointments meet the access standard. For specialty mental health appointments with behavioral health providers, more than three-fourths of appointments met the access standard, and for psychiatry appointments, about two-thirds of appointments met the access standard (see table 7).<sup>56</sup> However, as noted previously, this measurement may overstate the amount of time servicemembers must wait before receiving care.

**Table 7: Percentage of the Military Health System's (MHS) Purchased Care System Specialty Mental Health Appointments that Met the Specialty Care Access Standard, April 2014 through August 2015**

	Behavioral Health Appointments	Psychiatry Appointments
North	76%	65%
South	80%	72%
West	80%	63%

Source: GAO analysis of Department of Defense data. | GAO-16-416

Notes: The data above includes appointments for only active duty servicemembers and activated National Guard and Reserve servicemembers. Providers included in the category of behavioral health include psychologists, social workers, and alcohol and drug counselors. This measure may overstate the time to care because it does not account for factors such as the time a servicemember may take after receiving a referral authorization before calling for an appointment.

<sup>55</sup>At the time of our review, data on mental health access in TRICARE's overseas region were not available; however, fiscal year 2014 mental health utilization data show that purchased care is used much less frequently overseas than it is used domestically.

<sup>56</sup>For each of the three TRICARE domestic regions, mental health appointment data are tracked separately for psychiatry and behavioral health appointments. TRICARE regional office officials reported that providers included in the category of behavioral health include psychologists, social workers, and alcohol and drug counselors.

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## DOD Surveys and Other Sources of Access Information Show That Some Servicemembers Have Experienced Mental Health Access Problems

Various DOD and Air Force surveys have found that some servicemembers experienced problems or have concerns about accessing mental health care.<sup>57</sup> For example, fiscal year 2011 through fiscal year 2014 data from DOD's Health Care Survey of DOD Beneficiaries—the principal tool with which DHA monitors the opinions and experiences of MHS beneficiaries directly—found that about one in three servicemembers who had a need for treatment or counseling experienced problems accessing mental health care in the MHS. (See app. II, table 13.) Service-specific results were generally similar to the overall results, although fewer active duty Air Force servicemembers experienced access problems compared to the other services, with an estimated 23 to 29 percent of Air Force servicemembers experiencing problems over the four-year period. Similar to the results for active duty servicemembers, about an estimated one-third of reservists experienced problems accessing mental health treatment over the four years.

Results from the Air Force's 2013 Community Assessment survey found that the majority of Air Force servicemembers did not feel that various mental health access barriers related to logistics and appointment scheduling were applicable to them.<sup>58</sup> (See app. II, table 14.) However, it is unknown what percentage of Air Force servicemembers responding to the 2013 Community Assessment actually sought counseling or other mental health care. In response to various questions related to potential access barriers, the 2013 survey results estimate that the listed access barriers did not affect the majority of Air Force servicemembers' ability to seek counseling or other mental health care services. For example, in response to the statement "It would be difficult to schedule an appointment," 81 percent of active duty Air Force servicemembers reported that this statement "does not describe me at all."

Additional DOD surveys specific to purchased care have also identified some potential problems regarding access to civilian mental health providers. For example, DOD's nationwide TRICARE Standard Surveys of Civilian Providers have found that less than half of civilian mental

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<sup>57</sup>For detailed information on the results of these surveys related to access to mental health care, including information about response rates and margins of error, see appendix II.

<sup>58</sup>The Community Assessment is an Air Force-wide survey that has been conducted about every 2 years since 1991 to measure community assets, needs, and results. The survey contains questions related to mental health perceptions, among other topics.

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health providers were accepting new TRICARE patients. (See app. II, table 15.) As we have previously reported, surveys from 2008 through 2011 estimated that only about 39 percent of civilian mental health providers were accepting any new TRICARE patients.<sup>59</sup> Data from the 2012 and 2013 TRICARE Standard Survey of Civilian Providers provided by DOD showed that this percentage had not improved over time, with an estimated 37 percent of civilian mental health providers accepting new TRICARE patients during the surveys. A TRICARE Regional Office official suggested that the challenge of finding a civilian mental health provider who is accepting new TRICARE patients should be less of a concern for Prime beneficiaries, because they would typically be seeking care from TRICARE network providers. The Regional Office official also said that they would assist any Prime beneficiary who reported challenges in finding a mental health provider, and a DOD official explained that if a mental health specialist is not available, the contractor (domestic or overseas) is contractually responsible for locating a non-network provider for Prime beneficiaries.

Additionally, DOD's TRICARE Standard Survey of Beneficiaries, which surveyed beneficiaries not enrolled in TRICARE Prime (that is, nonenrolled beneficiaries), including reservists with TRS, have also found that these beneficiaries experienced problems accessing a civilian mental health care provider.<sup>60</sup> (See app. II, table 16.) As we previously reported, surveys from 2008 through 2011 show that an estimated 28 percent of these nonenrolled beneficiaries experienced problems accessing civilian mental health care providers.<sup>61</sup> The 2012 and 2013 survey data show similar results, with an estimated 30 percent of nonenrolled beneficiaries

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<sup>59</sup>See GAO, *Defense Health Care: TRICARE Multiyear Surveys Indicate Problems with Access to Care for Nonenrolled Beneficiaries*, [GAO-13-364](#) (Washington, D.C.: Apr. 2, 2013).

<sup>60</sup>The TRICARE Standard Survey of Beneficiaries does not include Prime beneficiaries such as active duty servicemembers. Because TRS is the same benefit as the TRICARE Standard and Extra options, DOD monitors TRS beneficiaries' access to civilian providers as a part of its efforts to monitor access to civilian providers among beneficiaries who use TRICARE Standard and Extra. We have previously determined that jointly monitoring access for TRS beneficiaries and TRICARE Standard and Extra beneficiaries was a reasonable approach. See GAO, *Defense Health Care: DOD Lacks Assurance That Selected Reserve Members Are Informed About TRICARE Reserve Select*, [GAO-11-551](#) (Washington, D.C.: June 3, 2011).

<sup>61</sup>See [GAO-13-364](#).

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experiencing problems accessing services provided by a civilian mental health care provider.

In addition to surveys, recent research related to access to DOD mental health has also identified potential problems with access to care for some types of servicemembers. For example, a 2015 RAND Corporation study about access to behavioral health care found that active duty servicemembers classified as living in geographically remote areas made up to 20 percent fewer visits to behavioral health care providers than those living closer to facilities.<sup>62</sup> The RAND study also found that remote servicemembers needing or wanting behavioral health care face challenges similar to those faced by the rural population generally, including a shortage of appropriate service providers, long travel times to facilities, and few travel options. Additionally, the study found that gaps in broadband service in rural and remote areas impede the use of telehealth services. However, despite the high representation of reservists who live in geographically remote areas, RAND's analyses did not find the remoteness associated with less utilization of behavioral health care in that population.

Two Army-specific studies also identified some concerns with access to mental health care. A 2010 survey of Army mental health care providers and their patients found that while the majority of the providers reported being able to spend sufficient time with patients (92 percent) and schedule encounters to meet patients' needs (82 percent), the providers also identified services for which access to treatment was more limited and patient subgroups with an unmet need for additional clinical care or services.<sup>63</sup> For example, the providers' patients with more severe symptoms and diagnostic and clinical complexity reported higher rates of access problems. Additionally, a study of three samples of Army National Guard soldiers at three time points found that while stigma was the most frequently cited barrier to care (34 percent of soldiers overall), 31 percent of the soldiers reported at least one significant barrier to care related to

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<sup>62</sup>Ryan Andrew Brown et al., *Access to Behavioral Health Care for Geographically Remote Service Members and Dependents in the U.S.* (Santa Monica, CA: RAND Corporation, 2015). The RAND study classified servicemembers as living in geographically remote areas if they lived more than 30 minutes away from behavioral health care or in a low provider density area.

<sup>63</sup>Joyce C. West et al., "Mental Health Treatment Access and Quality in the Army: Survey of Mental Health Clinicians." *Journal of Psychiatric Practice*. Vol. 20, No. 6 (2014).

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logistics (where to get help, inadequate transport, difficult to schedule, getting time off work, care costs too much money, no providers available, long distances to care).<sup>64</sup> One logistical barrier—mental health treatment costing too much—was the most commonly reported, with 16 percent of soldiers overall noting this barrier.

We also learned about mental health access challenges in our interviews with service officials representing reservists and with representatives from an association representing Reserve officers. Both groups identified mental health access challenges experienced by reservists. However, service officials reported that they typically hear about these types of access challenges anecdotally and do not systematically collect information about access challenges faced by reservists. For example, while activated reservists or those with line of duty mental health conditions may have a right to DOD health care, Army National Guard and Army Reserve officials and representatives from the Reserve Officers Association reported that reservists' access may be limited by their distance from an MTF or from other resources available in their area, particularly if they live in a geographically remote area. An Army National Guard official and a Navy and Marine Corps Reserve official noted that in some communities reservists face challenges finding providers that will accept TRICARE or providers that are accepting new patients. National Guard officials and a Navy and Marine Corps Reserve official also noted that the TRS premiums and other costs are another access barrier for some reservists, particularly for lower ranking servicemembers or those who are otherwise unemployed. Additionally, representatives from the Reserve Officers Association and the Army National Guard reported challenges associated with putting reservists on orders to receive care related to a line of duty condition. An Army National Guard official noted, for example, that the minimum time for orders is an 8-hour day or a 4-hour drill period, which means servicemembers would have to be put on active duty for that day, precluding them from doing anything else, including working their civilian jobs.

While access problems were identified in surveys, studies, and our interviews, DOD's current work to establish a governance structure for mental health access oversight, which includes the implementation of the

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<sup>64</sup>Marcia Valenstein et al., "Reported Barriers to Mental Health Care in Three Samples of U.S. Army National Guard Soldiers at Three Time Points." *Journal of Traumatic Stress*. Vol. 27, No. 4 (2014).

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department's mental health strategic plan, may address some of these concerns. For example, the governance structure may improve accountability when access standards are not being met. However, some problems such as finding available mental health providers may remain because, as noted previously, provider shortages affect the entire health system and are not specific to DOD or the TRICARE program. It is too early to determine the extent to which DOD's ongoing efforts will resolve all of these concerns.

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## Mental Health Care Available in Deployed Settings Varies Depending on the Environment, and Access Data Are Generally Not Available

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### Mental Health Care Available in Deployed Settings Varies by Environment, Is Delivered Through Various Means, and Has Decreased Along with Deployments

Officials from the Army, Navy, and Marine Corps reported that the availability of mental health care varies depending on the deployed environment. They noted that such care is more variable than the services available domestically and that in general, deployed reservists and DOD civilians have access to the same mental health care available to active duty servicemembers in that deployed environment. This is consistent with findings from our prior work. For example, in 2013 we reported that the health care services that are available aboard Navy vessels largely depend on the type and class of vessel.<sup>65</sup> Larger vessels generally offer a wider range of services—including specialized services—than do smaller vessels, due largely to their more robust crew levels and capabilities.

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<sup>65</sup>See GAO, *Military Personnel: DOD Has Taken Steps to Meet the Health Needs of Deployed Servicewomen, but Actions Are Needed to Enhance Care for Sexual Assault Victims*, [GAO-13-182](#) (Washington, D.C.: Jan. 29, 2013).

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Additionally, MHAT studies about the mental health care available in Afghanistan, where a significant number of deployed servicemembers have been located in recent years, have found that the mental health resources available there were robust but unevenly distributed. The Joint Mental Health Advisory Team 8 (J-MHAT 8) study, conducted in 2012, noted that the range of mental health care provided in Afghanistan included emergency psychiatric care and medical evacuations, psychotherapy, medication management, traumatic event management, outreach, education, awareness training, and medical evaluations.<sup>66</sup> However, the study also found that the providers and clinics that deliver these services were unevenly distributed, resulting in a small number of clinics providing the bulk of the services.

Navy and Marine Corps officials told us that the availability of mental health care in deployed settings varies depending on a number of factors. For example, a Navy official cited factors including the type of deployed setting, the number of deployed personnel, and the assessed needs of a particular unit. A Marine Corps official noted some additional factors, such as the deployment purpose and the expected stress from the deployment. This official stated that Navy and Marine commanders, after consulting with psychological health advisors and considering a variety of factors, generally determine what, if any, mental health resources deploy with particular units.

Mental health care is provided to deployed servicemembers and DOD civilians through various means. Army officials told us, for example, that mental health care in deployed settings is provided to servicemembers through behavioral health officers assigned to brigade combat teams, as well as through combat operational stress control teams.<sup>67</sup> An Army

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<sup>66</sup>Office of the Surgeon General, United States Army Medical Command, Office of the Command Surgeon Headquarters, US Army Central Command, and Office of the Surgeon General, US Forces Afghanistan, *Joint Mental Health Advisory Team 8 (J-MHAT 8) Operation Enduring Freedom 2012 Afghanistan*. (Aug. 12, 2013). The Office of the Surgeon General of the Army took the lead in mission execution for the 2012 study and was supported by the Offices of the Surgeons' General of the Navy and Air Force, along with the Office of the Medical Officer of the Marine Corps. The 2012 study was the second Afghanistan study to have joint representation among the services.

<sup>67</sup>The Army reported that deployed DOD civilians would not be likely to receive care from behavioral health officers assigned to brigade combat teams, as these civilians are typically located near larger bases and would more likely be treated at a facility such as a combat support hospital.

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official stated that each brigade deploys with two different behavioral health officers—frequently psychologists and social workers—and staff that support these officers with providing care. The official said that the combat operational stress control teams comprise up to 30 individuals that assist with prevention initiatives and provide support for mental health issues for each brigade combat team. The official added that the division would also have a psychiatrist who helps coordinate care. Navy and Air Force officials similarly stated that in certain deployed settings mental health providers may be co-located or embedded with deployed personnel. The Marine Corps' combat operational stress control program includes teams of Marine leaders, religious ministry personnel, and mental health providers assigned to battalion-sized units that have been trained in identifying, managing, and preventing combat stress issues.

Clinic settings and telehealth are also used to deliver mental health care in certain deployed settings. For example, the report for J-MHAT 8 described clinic settings in Afghanistan through which servicemembers received care. That study found, for example, that the majority of mental health services provided in Afghanistan were provided at combat stress clinics and behavioral health clinics, which are outpatient clinics that provide mental health care to any walk-in patients. Mental health care in Afghanistan was also provided in restoration clinics—residential treatment facilities designed to maximize restoration and return-to-duty for servicemembers. J-MHAT 8 also found that telehealth was used in Afghanistan, although most providers surveyed reported that they preferred in-person counseling as a method of care delivery for servicemembers. Army officials noted that over the past several years, the Army has increasingly leveraged telehealth to increase access to care, particularly in remote locations.

Data on the number of deployed mental health providers in Afghanistan show that the number of providers available to offer mental health care services increased from 2005 through 2010, before decreasing as the United States scaled back its military operations (see fig. 7).<sup>68</sup> Army officials told us that there are generally more behavioral health providers

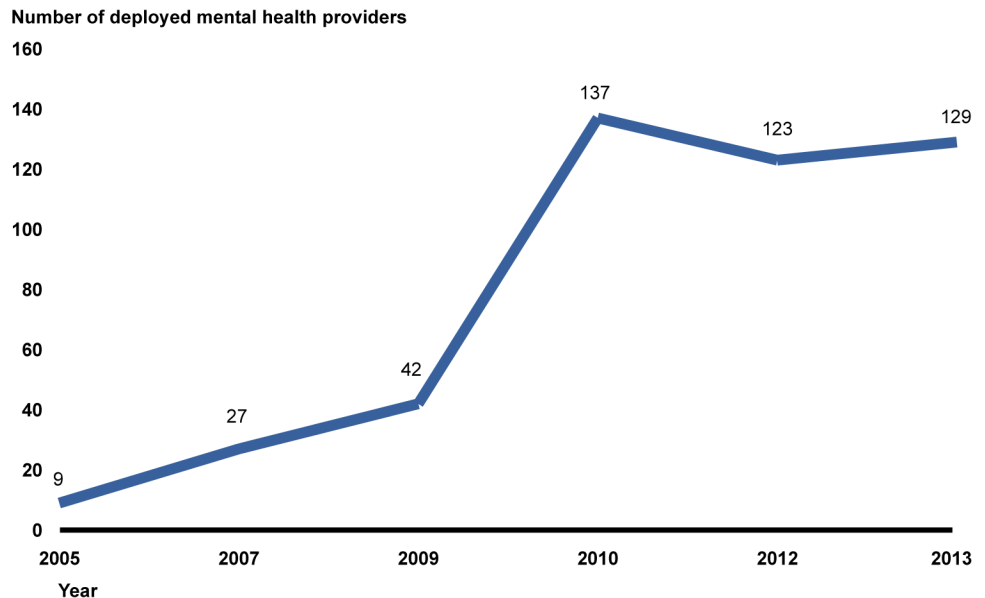
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<sup>68</sup>See Office of the Surgeon General, United States Army Medical Command, Office of the Command Surgeon Headquarters, US Army Central Command, and Office of the Command Surgeon US Forces Afghanistan, *Mental Health Advisory Team (MHAT) 9 Operation Enduring Freedom (OEF) 2013 Afghanistan*. (October 10, 2013) p.57.



deployed to areas of combat operations, such as Afghanistan, compared to other non-combat missions.

**Figure 7: Total Number of Deployed Mental Health Providers for Operation Enduring Freedom, Afghanistan, 2005 to 2013**



Source: GAO analysis of Department of Defense data. | GAO-16-416

Notes: Data were taken from the report for Mental Health Advisory Team (MHAT) 9. See Office of the Surgeon General, United States Army Medical Command, Office of the Command Surgeon Headquarters, US Army Central Command, and Office of the Command Surgeon US Forces Afghanistan, *Mental Health Advisory Team (MHAT) 9 Operation Enduring Freedom (OEF) 2013 Afghanistan*. (October 10, 2013) p.57. We define mental health providers as licensed or certified clinical providers—those that have met the minimum requirements needed to obtain and maintain a license or certification—including psychiatrists, psychologists, mental health nurse practitioners, licensed social workers, and other licensed providers. Therefore we excluded from our analysis any occupational therapist technicians who were deployed to Afghanistan during the same time frame. The remaining provider numbers for the Air Force, Army, and Navy were then totaled.

Data provided by the military services and DOD regarding the total number of mental health providers deployed to any location since fiscal year 2014 suggest that deployed mental health provider availability has continued to decrease since the last MHAT study in Afghanistan—MHAT 9 in 2013—when there were 129 mental health providers in Afghanistan, consistent with the overall drawdown in deployed forces. For fiscal year 2014, the services reported a total of 114 mental health providers in any

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deployed setting (of these, the Army reported 64, the Air Force reported 29, the Navy reported 21, and the Marine Corps reported none).<sup>69</sup> As of February 2016, DOD reported that there were a total of 36 mental health providers in deployed settings, of which 10 were located in Afghanistan. Army officials confirmed that the number of deployed mental health providers has decreased since 2013 in accordance with the overall force drawdown in Afghanistan. Army and DOD officials also reported some additional factors that have affected the total number of deployed mental health providers in recent years, such as troops no longer performing combat patrols and the behavioral health providers' non-combat missions, which include providing local support to Allied missions and supporting redeployment operations.

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**Mental Health Access  
Data for Deployed  
Settings Are Generally Not  
Available, Although  
Afghanistan Studies Show  
Some Access  
Improvement since 2009**

According to DOD, data on access to mental health care in deployed settings are generally not available, and DOD's access to care standards do not apply in these environments. For example, an Army official noted that the Army's access to data on mental health encounters in deployed settings is fairly limited. He stated that data availability depends on factors such as commanders' preferences regarding what data to record and internet connectivity at the deployed site. In lieu of data on access, a DOD official noted that DOD has reviewed the staffing ratios in the MHAT reports in order to monitor access in the deployed environment. In recent years MHAT data has indicated that the number of mental health providers in Afghanistan was sufficient to meet mental health needs of deployed servicemembers, according to the 2013 MHAT 9 report.

The MHAT studies conducted in Afghanistan from 2009 through 2013 showed some improvement in active duty servicemembers' opinions about access to mental health care. As part of the studies, servicemembers were surveyed about various logistical barriers to accessing mental health care, and the responses were separated by those servicemembers who screened positive for mental health problems

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<sup>69</sup>The Marine Corps reported that it did not deploy any mental health providers in 2014 for the following two reasons: (1) since the majority of Marines requiring mental health services are not deployed, Marine leaders determined it best to allow their mental health providers to remain behind and provide care for those in need; (2) most Marine units deploy to regions or areas where other services' mental health providers are already deployed alongside or relatively near the Marine unit, allowing the Marine Corps to leverage joint force medical support to provide mental health care for any Marine Corps servicemembers in need of treatment.

and those who did not (see table 8). The MHAT studies found that the percentage of servicemembers agreeing with the statements “mental health services aren’t available” and “it is too difficult to get to the location where the mental health specialist is” decreased significantly since 2009.

**Table 8: Percentage of Army Servicemembers Who Screen Positive and Who Do Not Screen Positive for Any Mental Health Problems Reporting Barriers to Mental Health Care, 2009-2013**

	Percentage Agreeing or Strongly Agreeing							
	2009		2010		2012		2013	
	Screen positive	Do not screen positive	Screen positive	Do not screen positive	Screen positive	Do not screen positive	Screen positive	Do not screen positive
There would be difficulty getting time off work for treatment	50.2%	20.7%	45.0%	17.5%	47.7%	19.1%	45.6%	17.8%
It's too difficult to get to the location where the mental health specialist is	41.5%	18.8%	31.0%	12.8%	27.3%	11.0%	26.9%	10.8%
It is difficult to get an appointment	31.1%	12.0%	26.3%	9.8%	28.2%	10.6%	26.2%	9.8%
My leaders discourage the use of mental health services	20.8%	6.6%	16.1%	4.9%	16.2%	4.9%	15.6%	4.7%
Mental health services aren't available	35.1%	15.15	27.1%	10.9%	14.6%	5.3%	11.7%	4.2%
I don't know where to get help	20.2%	6.5%	15.7%	4.9%	22.6%	7.4%	20.1%	6.5%

Source: Department of Defense data. | GAO-16-416

Notes: Data were taken from the report for Mental Health Advisory Team (MHAT) 9. See Office of the Surgeon General, United States Army Medical Command, Office of the Command Surgeon Headquarters, US Army Central Command, and Office of the Command Surgeon US Forces Afghanistan, *Mental Health Advisory Team (MHAT) 9 Operation Enduring Freedom (OEF) 2013 Afghanistan*. (Oct. 10, 2013). There were 702 servicemembers included in the 2009 study sample, 946 servicemembers in the 2010 sample, 619 servicemembers in the 2012 sample, and 849 servicemembers in the 2013 sample. To allow for comparisons across years, annual results were adjusted to account for demographic differences in the number of months the sampled servicemembers were deployed.

However, as table 8 shows, the MHAT studies from 2009 through 2013 also found that some servicemembers continued to experience barriers accessing mental health services. For example, the MHAT studies consistently found that a higher percentage of Army servicemembers who screened positive for mental health problems experienced barriers to mental health care compared with those who did not screen positive. The studies also found that the percentage of servicemembers who experienced some access barriers remained fairly stable from 2009 through 2013. For example, during this period the percentage of servicemembers reporting that they would experience difficulty getting

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time off work for treatment remained the highest compared to the other access barrier questions. In addition, the MHAT studies also identified stigma as a strong potential barrier to seeking mental health care, with servicemembers that screened positive for mental health conditions reporting high levels of stigma-related concerns. For example, in the 2013 study, 49 percent of Army servicemembers that screened positive for a mental health condition reported that they agreed or strongly agreed that they would be seen as weak if they were to seek mental health care.

Although the MHAT studies showed that some servicemembers continued to experience barriers accessing mental health services over time, as noted previously, the number of servicemembers deployed to Afghanistan has declined in recent years. Additionally, DOD reported in February 2016 that it was working to expand its telehealth efforts there and that efforts such as circulating providers throughout the battlefield and organizing providers in teams had improved the utilization and efficiency of deployed mental health providers since the last MHAT report in 2013.

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## Conclusions

Providing our nation's military servicemembers with timely access to mental health care is a crucial responsibility of DHA and the military services. Recent data show that DOD is generally meeting three of its four appointment wait time access standards in its direct care system—where the majority of outpatient mental health care is delivered. However, recent DOD surveys also show that about a third of servicemembers reported that they experienced problems accessing care—indicating that servicemember perceptions of access and DOD's access to care standards may not be aligned. Our work also shows that despite federal internal control standards that call for agencies to have sufficient information to monitor agency performance, DOD lacks an important standard for follow-up appointments, which represent nearly two-thirds of the mental health care provided in the MHS's direct care system. Without such a standard, DOD does not have a mechanism for holding MTFs or the services accountable for providing timely access to the most common mental health care provided in the direct care system.

Nonetheless, DOD has efforts underway to expand the mental health care available to its servicemembers and to improve access to that care. For example, DOD's current work to establish a governance structure for the oversight of mental health access, which includes the department's mental health strategic plan, could help DOD and the military services identify, monitor, and improve the performance of those military services

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or MTFs not performing up to standards and help ensure that servicemembers have timely access to necessary mental health care. However, it is too soon to determine what the impact of DOD's efforts will be on improving access. Additionally, some factors outside of DOD's control, such as the nationwide shortage of mental health providers, may continue to limit DOD's ability to address all identified access problems.

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## Recommendation for Executive Action

To enhance oversight of access to mental health care and help ensure that servicemembers have timely access to mental health care, we recommend that that Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to establish an access standard for mental health follow-up appointments and regularly monitor data on these appointments.

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## Agency Comments

We provided a draft of this report to DOD for comment. DOD provided written comments, which are reproduced in appendix III. DOD also provided technical comments that were incorporated, as appropriate.

In its written comments, DOD concurred with our recommendation, but noted that developing a standard for follow-up mental health appointments would be difficult. Nonetheless, the agency reported that it would review appropriate methods to develop follow-up standards. DOD did not provide a time frame for implementing this recommendation.

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We are sending copies of this report to the Secretary of Defense, appropriate congressional committees, and other interested parties. In addition, the report is available at no charge on the GAO website at <http://www.gao.gov>.

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If you or your staff have any questions about this report, please contact me at (202) 512-7114 or [williamsonr@gao.gov](mailto:williamsonr@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix III.

A handwritten signature in black ink, reading "Randall B. Williamson". The signature is written in a cursive, flowing style.

Randall B. Williamson  
Director, Health Care

# Appendix I: Fiscal Year 2015 Department of Defense (DOD) Mental Health Provider Staffing Shortages

This appendix provides results from our analysis of DOD fiscal year 2015 quarterly mental health staffing reports by military service and the National Capital Region (NCR) Medical Directorate. These reports are submitted by the services and the NCR Medical Directorate to the Office of the Assistant Secretary of Defense for Health Affairs human capital office each quarter to provide status updates on mental health care provider staffing levels.

**Table 9: Total Number of Authorized and Filled Positions for Army Mental Health Providers as of September 2015**

Provider type	Authorized	Assigned/ on-board	Provider shortage (%)
Psychologist	964	1202	238 (24.6%)
Psychiatrist	442	389	-53 (-11.9%)
Social worker	1492	1492	0 (0.0%)
Mental health nurse practitioner	78	105	27 (34.6%)
Other licensed provider	1	0	-1 (-100.0%)
<b>Total</b>	<b>2977</b>	<b>3188</b>	<b>211 (7.1%)</b>

Source: GAO analysis of Department of Defense data. | GAO-16-416

Note: An authorized position refers to a position that a Department of Defense component has approved for funding for a specific fiscal year.

**Table 10: Total Number of Authorized and Filled Positions for Air Force Mental Health Providers as of September 2015**

Provider type	Authorized	Assigned/ on-board	Provider shortage (%)
Psychologist	415	368	-47 (-11.3%)
Psychiatrist	178	138	-41 <sup>a</sup> (-22.8%)
Social worker	587	520	-67 (-11.4%)
Mental health nurse practitioner	26	35	9 (34.6%)
Other licensed provider	0	0	0 (0.0%)
<b>Total</b>	<b>1206</b>	<b>1061</b>	<b>-146<sup>a</sup> (-12.1%)</b>

Source: GAO analysis of Department of Defense data. | GAO-16-416

Note: An authorized position refers to a position that a Department of Defense component has approved for funding for a specific fiscal year.

<sup>a</sup>Numbers do not total due to rounding to the nearest number of full-time equivalent positions.

**Table 11: Total Number of Authorized and Filled Positions for Navy Mental Health Providers as of September 2015**

Provider type	Authorized	Assigned/ on-board	Provider shortage (%)
Psychologist	413	344	-69 (-16.7%)
Psychiatrist	199	175	-24 (-12.1%)
Social worker	269	220	-49 (-18.2%)
Mental health nurse practitioner	39	46	7 (17.9%)
Other licensed provider	60	47	-13 (-21.7%)
<b>Total</b>	<b>980</b>	<b>832</b>	<b>-148 (-15.1%)</b>

Source: GAO analysis of Department of Defense data. | GAO-16-416

Note: An authorized position refers to a position that a Department of Defense component has approved for funding for a specific fiscal year.

**Table 12: Total Number of Authorized and Filled Positions for National Capital Region (NCR) Medical Directorate Mental Health Providers as of September 2015**

Provider type	Authorized	Assigned/ on-board	Provider shortage (%)
Psychologist	69	56	-13 (-18.8%)
Psychiatrist	45	35	-10 (-22.2%)
Social worker	109	90	-19 (-17.4%)
Mental health nurse practitioner	9	10	1 (11.1%)
Other licensed provider	14	5	-9 (-64.3%)
<b>Total</b>	<b>246</b>	<b>196</b>	<b>-50 (-20.3%)</b>

Source: GAO analysis of Department of Defense data. | GAO-16-416

Note: An authorized position refers to a position that a Department of Defense component has approved for funding for a specific fiscal year.



# Appendix II: Department of Defense (DOD) and Air Force Survey Data Related to Mental Health Access

Tables 13 through 16 contain results for questions relevant to access to mental health care in DOD’s Military Health System from four recent surveys. The four surveys are: (1) the fiscal year 2011-2014 Health Care Survey of DOD Beneficiaries; (2) the 2013 Air Force Community Assessment survey, (3) the TRICARE Standard Survey of Civilian Providers for 2012 and 2013; and (4) the TRICARE Standard Survey of Beneficiaries for 2012 and 2013.

**Table 13: Estimated Percentage of Servicemembers Who Experienced Mental Health Access Problems, Health Care Survey of Department of Defense (DOD) Beneficiaries, Fiscal Year (FY) 2011 through 2014**

		FY 2011 <sup>a</sup>	FY 2012 <sup>b</sup>	FY 2013 <sup>c</sup>	FY 2014 <sup>d</sup>
Beneficiaries reporting a need for treatment or counseling in the prior year that experienced problems accessing mental health treatment	All active duty servicemembers (no reservists) <sup>e</sup>	35%	38%	37%	36%
	Army	38%	41%	44%	39% <sup>f</sup>
	Navy	39%	37%	41%	38% <sup>g</sup>
	Marine Corps	27%	42% <sup>h</sup>	34% <sup>i</sup>	34% <sup>j</sup>
	Air Force	29%	27%	23%	29%
	Active and inactive reservists	33%	29%	40% <sup>k</sup>	35% <sup>l</sup>

Source: GAO analysis of DOD data. | GAO-16-416

Notes: Estimates are subject to margins of error of no more than ±10 percentage points at the 95 percent confidence level, unless otherwise noted, and have been adjusted to account for possible non-response bias. Respondents were considered to have experienced an access problem if they answered “a big problem” or “a small problem” to the question that asked: Based on the following: In the last 12 months, how much of a problem, if any, was it to get the treatment or counseling you needed through your health plan? Answer choices were “A big problem,” “A small problem,” or “Not a problem.”

<sup>a</sup>The overall unweighted response rate for the FY 2011 survey was about 23 percent.

<sup>b</sup>The overall unweighted response rate for the FY 2012 survey was about 20 percent.

<sup>c</sup>The overall unweighted response rate for the FY 2013 survey was about 18 percent.

<sup>d</sup>The overall unweighted response rate for the FY 2014 survey was about 9 percent.

<sup>e</sup>The term reservist refers to active or inactive National Guard or Reserve servicemembers.

<sup>f</sup>This estimate has a margin of error of ±11 percentage points.

<sup>g</sup>This estimate has a margin of error of ±14 percentage points.

<sup>h</sup>This estimate has a margin of error of ±14 percentage points.

<sup>i</sup>This estimate has a margin of error of ±18 percentage points.

<sup>j</sup>This estimate has a margin of error of ±12 percentage points.

<sup>k</sup>This estimate has a margin of error of ±12 percentage points.

<sup>l</sup>This estimate has a margin of error of ±14 percentage points.

**Table 14: Estimated Percentage of Air Force Servicemembers for Whom Various Access Barriers Did Not Apply, 2013 Air Force Community Assessment Survey**

Servicemembers responding that the following statements about access “does not describe me at all”	Active duty	Guard	Reserve
It would be difficult to schedule an appointment	81%	84%	83%
Hours of available services would not fit with my work schedule	73%	75%	75%
It would be difficult to get continuous treatment from one provider because either I move a lot, or the health care professionals move a lot	81%	91%	89%
It would be difficult for me to get child care	82%	85%	82%
I would not know where to get help	86%	83%	82%
I would not know how to select an appropriate mental health care provider	73%	70%	71%
It would be difficult for me to arrange transportation for services	94%	95%	94%

Source: GAO analysis of Air Force data. | GAO-16-416

Notes: For active duty servicemembers, the overall survey response rate was 24 percent. For Reserve servicemembers, the overall survey response rate was 13 percent. For Guard servicemembers, the overall survey response rate was 15 percent. Estimates are subject to margins of error of no more than  $\pm 2$  percentage points at the 95 percent confidence level, and have been adjusted to account for possible non-response bias.

**Table 15: Estimated Percentage of Mental Health Providers That Are Aware of and Accept TRICARE, TRICARE Standard Surveys of Civilian Providers, 2008 through 2013**

	2008-2011 <sup>a</sup>	2012-2013 <sup>b</sup>
Mental health care providers awareness of the TRICARE program <sup>c</sup>	68%	74%
Mental health care providers accepting any new TRICARE patients <sup>d</sup>	39%	37%
Mental health care providers accepting any new TRICARE patients if accepting new patients <sup>e</sup>	41%	39%
Mental health care providers accepting any new TRICARE patients if accepting new Medicare patients <sup>f</sup>	57%	56%
Categories of reasons for civilian mental health care providers not accepting new TRICARE patients <sup>g</sup>		
Not aware of TRICARE/not asked/don't know about TRICARE	30%	23%
Don't know/no answer	14%	13%
Reimbursement	11%	13%
Insurance image problems/issues with TRICARE in past	11%	9%
Specialty not covered	9%	15%
Not accepting patients	4%	4%
Miscellaneous <sup>h</sup>	21%	29%

Source: GAO analysis of Department of Defense data. | GAO-16-416

Notes: Mental health care provider responses from these surveys included responses from psychiatrists and the following non-physician mental health care providers: certified clinical social workers, certified psychiatric nurse specialists, clinical psychologists, certified marriage and family therapists, pastoral counselors, and mental health counselors. Estimates are subject to margins of

error of no more than  $\pm 3$  percentage points at the 95 percent confidence level, and have been adjusted to account for possible non-response bias.

<sup>a</sup>Overall response rate for the TRICARE Standard Surveys of Providers for 2008 through 2011 was about 42 percent.

<sup>b</sup>Overall response rate for the TRICARE Standard Surveys of Civilian Providers for 2012 and 2013 was 42 percent.

<sup>c</sup>Respondents answered yes to the following question: "Is the provider aware of the TRICARE health care program?"

<sup>d</sup>Respondents answered "for all claims" or on a "claim-by-claim basis" to the following question: "As of today, is the provider accepting new TRICARE Standard patients?"

<sup>e</sup>Respondents answered yes to questions that asked the following: "As of today, is the provider accepting any new patients?" and "As of today, is the provider accepting new TRICARE Standard patients?" The "yes" response to this question represents the providers' indication that they were accepting new TRICARE Standard patients on either a "claim-by-claim basis" or "for all claims."

<sup>f</sup>Respondents answered yes to questions that asked the following: "As of today, is the provider accepting new Medicare patients?" and "As of today, is the provider accepting new TRICARE Standard patients?" The "yes" response to this question represents the providers' indication that they were accepting new TRICARE Standard patients on either a "claim-by-claim basis" or "for all claims."

<sup>g</sup>Percentages across reason categories do not add up to 100 percent because respondents were able to select more than one response.

<sup>h</sup>The "miscellaneous" category includes reasons such as "not a provider/signed provider," and "working as locum tenens," which means that another provider substitutes for the regular provider when that regular provider is absent.

**Table 16: Estimated Percentage of Non-Prime TRICARE Beneficiaries Who Experienced Mental Health Access Problems, TRICARE Standard Surveys of Beneficiaries, 2008 through 2013**

	2008-2011 <sup>a</sup>	2012-2013 <sup>b</sup>
Nonenrolled beneficiaries that experienced problems accessing civilian mental health treatment <sup>c</sup>	28%	30%
Problems beneficiaries experienced accessing mental health treatment: <sup>d</sup>		
Doctor(s) not accepting TRICARE payments	45%	43%
Doctor(s) not taking any new TRICARE patients	25%	28%
Travel distance too long	24%	25%
Wait for an appointment too long	24%	25%
Doctor(s) not taking any new patients	17%	22%
Other	21%	21%

Source: GAO analysis of Department of Defense data. | GAO-16-416

Notes: Responses were analyzed for beneficiaries who reported that they received most of their care from TRICARE Standard or Extra, TRICARE Reserve Select or TRICARE Retired Reserve and who tried to get mental health care from a civilian provider during the past year. Estimates have been adjusted to account for possible non-response bias.

<sup>a</sup>Overall response rate for the TRICARE Standard Surveys of Beneficiaries for 2008 through 2011 was about 38 percent.

<sup>b</sup>Overall response rate for the TRICARE Standard Surveys of Beneficiaries for 2012 and 2013 was 28 percent.

<sup>c</sup>Respondents answered "a big problem" or "a small problem" to the question that asked: Based on the following: In the last 12 months, how much of a problem, if any, was it to get the treatment or counseling you needed through your health plan? Answer choices were "A big problem," "A small

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**Appendix II: Department of Defense (DOD) and  
Air Force Survey Data Related to Mental Health  
Access**

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problem," or "Not a problem." 2008-2011 estimates are subject to margins of error of no more than  $\pm 3$  percentage points at the 95 percent confidence level. 2012-2013 estimates are subject to margins of error of no more than  $\pm 6$  percentage points at the 95 percent confidence level.

<sup>d</sup>Based on the following: "In the last 12 months, what problems did you encounter in finding treatment or counseling?" Percentages across problem types do not add up to 100 percent because respondents were able to select more than one response. 2008-2011 estimates are subject to margins of error of no more than  $\pm 6$  percentage points at the 95 percent confidence level. 2012-2013 estimates are subject to margins of error of no more than  $\pm 14$  percentage points at the 95 percent confidence level.

# Appendix III: Comments from the Department of Defense



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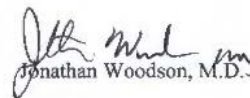
Mr. Randall Williamson  
Director, Health Care  
U.S. Government Accountability Office  
441 G Street, NW  
Washington DC 20548

APR 06 2016

Dear Mr. Williamson:

This is the Department of Defense (DoD) response to the Government Accountability Office (GAO) Draft Report GAO-16-416, "Defense Health Care: DoD is Meeting Most Mental Health Care Access Standards, But Needs a Standard for Follow-Up Appointments," dated February 29, 2016 (GAO Code 291291). The Department acknowledges receipt of the Draft Report and official written comments are enclosed. The DoD also collated suggested edits to the draft report in the enclosed SD Form 818. Mental health follow-up appointments as follow-up care is dependent on a large number of variables, including, but not limited to the patient's diagnosis, treatment protocol, and clinical judgement that make it impractical to set a follow-up access standard. However, DoD will review appropriate methods to develop standards for follow-up appointments consistent with GAO's recommendation and in accordance with the requirements outlined in the National Defense Authorization Act for Fiscal Year 2016, Section 704, "Access to health care under the TRICARE program for beneficiaries of TRICARE Prime."

Sincerely,

  
Jonathan Woodson, M.D.

Enclosures:  
As stated

**GAO DRAFT REPORT DATED FEBRUARY 29, 2016  
GAO-16-416 (GAO CODE 291291)**

**“DEFENSE HEALTH CARE: DOD IS MEETING MOST MENTAL HEALTH CARE  
ACCESS STANDARDS, BUT NEEDS A STANDARD FOR FOLLOW-UP  
APPOINTMENTS”**

**DEPARTMENT OF DEFENSE COMMENTS  
TO THE GAO RECOMMENDATION**

**RECOMMENDATION:** To enhance the Defense Health Agency’s (DHA) oversight of access to mental health care and help ensure that Service members have timely access to mental health care, the Government Accountability Office (GAO) recommends that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to establish an access standard for mental health follow-up appointments and regularly monitor data on these appointments.

**DEPARTMENT OF DEFENSE RESPONSE:** The Department of Defense (DoD) concurs with the GAO recommendation in the draft report “Defense Health Care: DoD is Meeting Most Mental Health Care Access Standards, but Needs a Standard for Follow-up Appointments,” dated February 29, 2016. A set standard for follow-up appointments in mental health or in any other product line is difficult because the timing of follow-up care is dependent on a large number of clinical variables including, but not limited to, the patient’s diagnosis, severity, treatment protocol, and the clinical judgement of providers. However, we will review appropriate methods to develop follow-up standards in accordance with the requirement outlined in NDAA 2016, Section 704, “Access to health care under the TRICARE program for beneficiaries of TRICARE Prime.”

The military Services have the responsibility and oversight for access to care they provide within the Military Health System (MHS). However, the Services, in collaboration with the DHA, are developing processes to ensure that an adequate number of appointments are available for timely follow-up on identified clinical issues. For example, the DoD has the ability to regularly monitor the future availability of follow-up appointments through the “Number of Days to Third Next Future” appointment metric via the TRICARE Operations Center. Analysis of these data will allow the MHS to track average wait time as a reflection of follow-up appointment availability. This will also allow assessment of the variability in wait times across military treatment facilities.

In the purchased care sector, access to care is monitored by the TRICARE Regional Offices, who ensure the Managed Care Support Contractors have established a provider network of sufficient size, composition, and mix of providers to adequately address the health care needs of TRICARE beneficiaries in the Prime Service Areas.

The DoD will continue to track the 7 and 30-day follow-up after hospitalization for mental illness (Healthcare Effectiveness Data and Information Set) measures for both purchased and direct care, as this access standard is consistently adopted and used by more than 90 percent of U.S. health plans.

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# Appendix IV: GAO Contact and Staff Acknowledgments

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## GAO Contact

Randall B. Williamson, (202) 512-7114 or [williamsonr@gao.gov](mailto:williamsonr@gao.gov).

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## Staff Acknowledgments

In addition to the contact named above, Lori Achman, Assistant Director; Muriel Brown; Krister Friday; Jacquelyn Hamilton; Dharani Ranganathan; Christina Ritchie; and Helen Sauer made key contributions to this report.

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